N.J.A.C. 10:52

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL

Title 10, Chapter 52 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

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

History

CHAPTER SOURCE AND EFFECTIVE DATE:

R.2018 d.104, effective April 16, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

CHAPTER HISTORICAL NOTE:

Chapter 52, Manual for Hospital Services, was adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c).

Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, Coverage, was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b).

Pursuant to Executive Order No. 66(1978), Subchapter 2, Admissions and Billing Procedures, was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1992 d.327, effective August 17, 1992, operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a).

Subchapter 5, Procedural and Methodological Regulations, Subchapter 6, Financial Reporting Principles and Concepts, Subchapter 7, Diagnosis Related Groups (DRG), Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993, to expire May 10, 1993. See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 1582(a), 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1995 d.123, effective February 3, 1995. As a part of R.1995 d.123, Chapter 52 was renamed Hospital Services Manual, and Subchapter 1, Coverage, Subchapter 2, Admission and Billing Procedures, Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart--Maternity and Pediatric Services, Subchapter 4, Basis of Payment for Hospital Services, and Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, were adopted as new rules, effective April 17, 1995. See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Subchapter 10, Charity Care, was adopted as R.1995 d.258, effective May 15, 1995. See: 27 N.J.R. 656(a), 27 N.J.R. 1995(a).

Subchapter 12, Graduate Medical Education and Indirect Medical Education, was adopted as R.1997 d.43, effective January 21, 1997. See: *28 N.J.R. 4022(a)*, *29 N.J.R. 350(b)*.

Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was adopted as R.1997 d.520, effective January 5, 1998. See: *29 N.J.R. 1006(a)*, *30 N.J.R. 232(a)*.

Pursuant to Executive Order No. 66(1978), Chapter 52, Hospital Services Manual, was readopted as R.2000 d.29, effective December 21, 1999, and Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, was recodified as Subchapter 13, Eligibility for and Basis of Payment for Disproportionate Share Hospitals, Subchapter 10, Charity Care, was recodified as Subchapter 11, Charity Care, Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was recodified as Subchapter 12, Charity Care Component of the Disproportionate Share Hospital Subsidies, Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, was recodified as Subchapter 10, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, and Subchapter 12, Graduate Medical Education and Indirect Medical Education, was recodified as Subchapter 8, Graduate Medical Education and Indirect Medical Education, by R.2000 d.29, effective January 18, 2000. See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Chapter 52, Hospital Services Manual, was readopted as R.2005 d.214, effective June 9, 2005. See: *37 N.J.R. 436(a)*, *37 N.J.R. 2506(a)*.

Subchapter 14, Methodology for Establishing DRG Payment Rates for Inpatient Services at General Acute Care Hospitals Based on DRG Weights and a Statewide Base Rate, was adopted as new rules by R.2009 d.249, effective August 3, 2009. See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Chapter 52, Hospital Services Manual, was readopted as R.2011 d.010, effective December 6, 2010. As a part of R.2011 d.010, Subchapter 10, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, was renamed Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, effective January 3, 2011. See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 52, Hospital Services Manual, was scheduled to expire on December 6, 2017. See: *43 N.J.R. 1203(a)*.

Chapter 52, Hospital Services Manual, was readopted as R.2018 d.104, effective April 16, 2018. See: Source and Effective Date. See, also, section annotations.

Annotations

Notes

Chapter Notes

Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 52, Hospital Services Manual, expires on April 16, 2025.

N.J.A.C. 10:52-1.1

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.1 Purpose and scope

(a) This chapter outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid/NJ FamilyCare fee-for service beneficiaries. These policies and procedures apply to general hospitals, special hospitals, rehabilitation hospitals, and psychiatric hospitals, unless specifically indicated otherwise.

(b) Unless otherwise stated, the rules of this chapter apply to Medicaid/NJ FamilyCare fee-for-service beneficiaries and to Medicaid/NJ FamilyCare fee-for-service services that are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services that are to be provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO in accordance with the Division's rules for MCOs at *N.J.A.C. 10:74*, the MCO's policies and procedures, and the MCO's provider contract with the State, and all amendments thereto.

History

HISTORY:

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to Medicaid and NJ KidCare fee-for service beneficiaries for a reference to Medicaid recipients, and substituted a reference to psychiatric hospitals for a reference to private psychiatric hospitals; and added (b).

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

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

In (a), substituted "FamilyCare" for "KidCare"; rewrote (b).

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a), substituted "These" for "The hospitals that are included in these" and "apply to" for "are".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Substituted "Medicaid/NJ" for "Medicaid and NJ" throughout; in (a), inserted a comma following the third occurrence of "hospitals"; and in (b), substituted the first two occurrence of "that" for "which".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-1.2

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

§ 10:52-1.2 Definitions

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

"Adult acute partial hospital" or "APH" means an intensive and time-limited acute psychiatric service for beneficiaries 18 years of age or older who are experiencing, or are at risk for, rapid decompensation. This mental health service is intended to minimize the need for hospitalization. See *N.J.A.C. 10:52A*.

"Advanced practice nurse (APN)" means a person currently licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with *N.J.A.C. 13:37-7*, and with *N.J.S.A. 45:11-24* and 45 through 52, or similarly licensed and certified by a comparable agency of the state in which he or she practices.

"Base year" means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

"Bundled drug service" means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost of the drug, the drug product and ancillary services, such as, but not limited to, case management and laboratory services.

"Centers for Medicare & Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program.

"Clinically licensed mental health professional" means a mental health professional possessing a Master's or Doctoral degree from an accredited university in psychiatry, psychology, social work, psychiatric nursing or psychiatric rehabilitation counseling. In addition to the degree, the applicable training must be completed, including the appropriate residency (fellowship), internship or student placement required by the professional standards of the respective discipline, as well as the applicable State license.

"Current Cost Base" means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period for the purposes of rate setting.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications, and consumption of a similar amount of resources.

"Disproportionate share hospital" means a hospital designated as such by the Commissioner of the Department of Human Services, in accordance with N.J.A.C. 10:52-13.

"Division" means the New Jersey Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

"Division of Disability Services (DDS)" means the agency located within the Department which is designated as the agency responsible for information and referral for all individuals with disabilities.

"DoAS" means the Division of Aging Services in the New Jersey Department of Human Services.

"DOH" means the State Department of Health.

"Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid/NJ FamilyCare-Children's Program-Plan A beneficiaries under 21 years of age for the purpose of assessing a beneficiary's health needs through initial and periodic

examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

"Entity," as used in *N.J.A.C. 10:52-1.3*, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

"Equalization Factor" means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs in setting Statewide standard costs per case.

"Financial Elements" means the reasonable cost of items approved as reimbursable under Medicaid (see *N.J.A.C. 10:52-5.9*).

"Group outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders which involves a group of usually four to 12 beneficiaries who have similar problems and treatment needs. The group meets regularly with a therapist who uses the interaction of the group members to relieve distressful symptoms and modify beneficiaries' behavior.

"Group outpatient hospital psychiatric services for youth or young adults" means an outpatient therapeutic intervention for a youth or young adult with similar behaviors or functionality provided in a group of no more than eight individuals, in which interventions are provided directly by or under the direction of a clinically licensed mental health professional.

"Grouper" means the logic that assigns cases into the appropriate Diagnosis Related Groups in accordance with the clinical and statistical information supplied.

"Hospital" means, pursuant to section 1861(e) of the Social Security Act (*42 U.S.C. § 1395x(e)*), an institution which meets the following requirements:

1. Is primarily engaged in providing diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons or is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons;

2. Maintains clinical records on all patients;

3. Has by-laws in effect with respect to its staff of physicians;

4. Requires every patient to be under the care of a physician;

5. Provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a registered professional nurse or licensed practical nurse on duty at all times;

6. Has in effect a hospital utilization review plan that meets the requirement of the law (Sec. 1861(K) of the Social Security Act); and has in place a discharge planning process that meets the requirements of the law (Sec. 1861(ee)) of the Social Security Act;

7. Is licensed as a hospital in the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located, or approved by the agency of the state or locality responsible for licensing hospitals meeting the standards established for such licensing;

8. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of health and safety of individuals who furnished services in the institution; and

9. For the purposes of *N.J.A.C. 10:52-1.3* only, is where the main inpatient hospital services are located.

"Hospital (Approved General)" means an institution which is approved to participate as a provider in the Division if it:

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid/NJ FamilyCare provider);

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act);

3. Has in effect a hospital utilization review plan applicable to all patients who received medical assistance under Medicaid (Title XIX) and NJ FamilyCare-Children's Program (Title XXI); and

4. Has signed a provider agreement to participate in and abide by Federal and State laws and regulations.

"Hospital (Approved Private Psychiatric)" means an institution which is approved to participate as a provider in the Division and:

1. Is licensed by the State of New Jersey as a psychiatric (mental-non-governmental) hospital or licensed as a private psychiatric hospital (non-governmental) by the appropriate agency under the laws of the respective state in which the hospital is located;

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a psychiatric hospital;

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX);

4. Meets the special Medicare standards relative to staffing requirements and clinical medical records; and,

5. Has signed a provider agreement to participate in and abide by Federal and State laws and regulations.

"Hospital (Approved Private Psychiatric)" facility that provides inpatient services to children under 21 years of age" means an institution that shall meet the requirements of paragraphs 1 through 5 above, listed in the definition of "Hospital (Approved Private Psychiatric)" or in addition to paragraphs 1 and 5 above, has facility accreditation by the Joint Commission.

"Hospital (Approved Special)" means an institution that is approved by the New Jersey State Department of Health as a special hospital (for definition of special hospital, see *N.J.A.C. 8:43G-1.3(b)*2) and which includes any hospital that assures the provision of comprehensive specialized diagnosis, care, treatment, and rehabilitation, where applicable, on an inpatient basis for one or more specific categories of patients; and is approved to participate as a provider in the Division if it meets the appropriate standards of participation for either a Special (Acute care or short-term) or a Comprehensive Rehabilitation Hospital and:

1. Is licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;

2. Is accredited by the Joint Commission or the Commission on Accreditation as a hospital or rehabilitation facility; and/or

3. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a hospital;

4. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

5. Has signed a provider agreement to participate in and abide by Federal and State laws and regulations.

"Individual outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders that is tailored for a beneficiary and is administered one on one, in

sessions which last between 30 minutes and one hour and which are provided on a regular basis for a defined period of time.

"Individual outpatient hospital psychiatric services for youth or young adults" means an outpatient therapeutic intervention that is provided directly to or on behalf of an individual youth or young adult, which may last between 30 minutes to one and a half hours and is provided on a regular basis as part of an integrated plan of service that may be supported by other strategies, interventions, and supports in the community. Such interventions may include family conferencing or family counseling with the purpose of the intervention to support a plan of treatment for the youth or young adult.

"Inliers" means inpatient cases which display common or typical patterns of resource use that are assigned to DRGs and have a length of stay within the high and low trim points.

"Inpatient" means a patient who has been admitted to an approved hospital as an inpatient on the recommendation of a physician, dentist or nurse midwife and receives room, board, and professional services in the hospital for a 24 hour period or longer, even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the hospital for 24 hours.

"Inpatient Hospital Services" means services that:

1. Are ordinarily furnished in a hospital for the care and treatment of inpatients;

2. Are furnished under the direction of a physician or dentist, except, as specified in *42 CFR 440.165* of the Social Security Act, for services provided by a certified nurse midwife;

3. Are furnished in an institution that:

i. Is maintained primarily for the care and treatment of patients with disorders including obstetrical services and services to the normal newborn;

ii. Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

iii. Except in the case of medical supervision of nurse-midwife services, as specified in *42 CFR 440.165* of the Social Security Act, or private inpatient psychiatric facilities for children under 21 years of age, meets the requirements for participation in Medicare as a hospital; and,

iv. Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of *42 CFR 482.30* of the Social Security Act, unless a waiver has been granted by the U.S. Secretary of Health and Human Services.

"Labor Market Area" means counties and municipalities in the State that are grouped in accordance with similar labor costs.

"Managed Long-Term Services and Supports (MLTSS)" means services that are provided under the Comprehensive Waiver through Medicaid/NJ FamilyCare managed care organization plans, the purpose of which is to support clients who meet nursing home level of care in the most appropriate setting to meet their specific needs.

"Medical social worker" means an individual who is licensed or certified in accordance with *N.J.S.A. 45:15BB-1* et seq. and *N.J.A.C. 13:44G* and meets the Medicare certification requirements for education (See *42 U.S.C. § 1395x*).

"Medication management" means medication services to evaluate, prescribe or administer and monitor a beneficiary's use of psychotropic medications provided by, or under the supervision of, a licensed physician or APN.

"Medication management for youth or young adults" means therapeutic services provided by a qualified medical/mental health professional who, within the scope of their practice, evaluates, prescribes,

administers, or monitors the use of therapeutic medications to assist in improving the ability of a youth or young adult to function in the community with, primarily, such therapeutic medications addressing the mental/behavioral health challenges of the youth or young adult. This service also includes providing education to the youth or young adult and their family/caregiver, as appropriate, about the benefits, side effects, and potential impact of the medications on the physical/mental health of the youth or young adult.

"Medication monitoring" means medication services provided to monitor a beneficiary's use of psychotropic medications under the supervision of a licensed physician or APN.

"Neonate" means a newborn less than 29 days of age.

"Nontherapeutic sterilization" means any procedure or operation, the purpose of which is to render an individual permanently incapable of reproducing and which is not either a necessary part of the treatment of an existing illness or injury, or medically indicated as an accompaniment of an operation on the female genitourinary tract. For the purpose of this definition, mental incapacity is not considered an illness or injury.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health for participation in Title XIX Medicaid and Title XXI Children's Health Insurance Program, which is known in New Jersey as NJ FamilyCare, and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid/NJ FamilyCare beneficiaries, (children and adults) who, due to medical disorders, developmental disabilities, and/or related cognitive impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for care and treatment of mental diseases that require continuous 24-hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

"Outliers" means patients who display atypical characteristics relative to other patients in a DRG and have lengths of stay either above or below the established trim points.

"Outpatient" means a patient registered in the outpatient department of a hospital or in a distinct part of that hospital who is expected to receive and who does receive professional services for less than a 24 hour period, regardless of the hour of admission; or whether or not a bed is used; or whether or not the patient remains in the hospital past midnight.

"Outpatient hospital services" means medically necessary items or services (preventive, diagnostic, rehabilitative, therapeutic, or palliative) provided to an outpatient, by or under the direction of a physician or dentist, except for the medical supervision of nurse midwife services; and/or by a psychiatric hospital or an excluded unit of a general hospital. The institution shall be licensed or formally approved as a hospital by the New Jersey State Department of Health, or certified by the officially designated authority in the state in which the hospital is located; shall meet the requirements for participation in Medicare (Title XVIII) as a hospital; and shall meet the criteria for participation as stated in *N.J.A.C. 10:52-1.3*.

"Partial hospital" or "PH" means an individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

"Patient" means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

"Physician services" means those services provided within the scope of practice of a doctor of medicine (M.D.) or osteopathy (D.O.) as defined by the laws of New Jersey, or if in practice in another state by the laws of that state, and which services are performed by or under the direction and/or personal supervision of the physician. (See also *N.J.A.C. 10:54-1.2*.)

"Preliminary Cost Base (PCB)" means the estimated revenue a hospital may collect based on an approved schedule of rates which includes DRG rate amounts and indirect costs not included in the all-

inclusive rate. Those indirect costs will either be the dollar amount specified or the estimated amount determined by a specific percentage adjustment to the rate.

"Rate year" means the year in which current reimbursement takes place.

"State fiscal year" means the State of New Jersey's fiscal year, which begins July 1 and ends the following June 30.

"Trim points" means the high and low length of stay cutoff points assigned to each DRG.

"Uniform Bill--Patient Summary (UB-92)" means the common billing and reporting form used by the hospital for each Medicaid inpatient.

"Young adult" means, for purposes of outpatient mental health/psychiatric services, an individual who is at least 18 years old and under 21 years old.

"Youth" means, for purposes of outpatient mental health/psychiatric services, an individual under 18 years old.

"Youth and young adult partial hospital" means an intensive, highly structured outpatient treatment program, provided in a hospital-based setting as approved by the Division of Medical Assistance and Health Services, that provides services designed primarily for youth and young adults under age 21 and intended to minimize the need for hospitalization that meets the requirements of this chapter and all other State rules and laws regarding youth and young adult partial hospital services.

History

HISTORY:

Amended by R.1997 d.396, effective September 15, 1997.

See: *29 N.J.R. 1003(a)*, *29 N.J.R. 4132(b)*.

Added "Entity"; and amended "Hospital" and "Outpatient hospital services".

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Deleted "Adjusted admissions" and "Informed Consent"; inserted "DHSS"; in "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)", substituted references to Medicaid and NJ KidCare--Plan A beneficiaries for references to Medicaid recipients, and inserted "or age 19 for NJ KidCare--Plan A beneficiaries" following "age"; in "Hospital", inserted a reference to *42 U.S.C. § 1395x(e)* in the introductory paragraph; in Hospital (Approved General), inserted references to NJ KidCare in 1 and 3; in "Hospital (Approved Special)", made internal designation changes; in "Inpatient", inserted a reference to nurse midwives; in "Outpatient hospital services", substituted "a psychiatric hospital or an excluded unit of a general hospital and the institution" for "private inpatient psychiatric facility for patients under 21 and over 65 years of age; and the institution that" following "and/or by", and changed N.J.A.C. reference; and changed "Uniform Bill--Patient Summary (UB-PS or UB-92)" definition to "Uniform Bill--Patient Summary (UB-92)".

Amended by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

Added "Disproportionate share hospital".

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

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

Rewrote the section.

Amended by R.2007 d.59, effective February 5, 2007.

See: *38 N.J.R. 4359(a)*, *39 N.J.R. 456(a)*.

Added definitions "Adult acute partial hospital", "Group outpatient hospital psychiatric services", "Individual outpatient hospital psychiatric services", "Medication management", "Medication monitoring" and "Partial hospital".

Amended by R.2008 d.375, effective December 15, 2008.

See: *40 N.J.R. 4667(a)*, *40 N.J.R. 6966(b)*.

Added definitions "Clinically licensed mental health professional", "Group outpatient hospital psychiatric services for youth or young adults", "Individual outpatient hospital psychiatric services for youth or young adults", "Medication management for youth or young adults", "Young adult", "Youth" and "Youth and young adult partial hospital".

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In definition "Adult acute partial hospital", inserted "See *N.J.A.C. 10:52A*."; and added definitions "Advanced practice nurse (APN)" and "Nursing facility (NF)".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted definition "DHSS"; added definitions "DoAS","DOH", and "Managed Long-Term Services and Supports (MLTSS)"; substituted definition "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)" for definition "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)", and in that definition, substituted "Medicaid/NJ" for "Medicaid and NJ"; rewrote definitions "Hospital (Approved Private Psychiatric)" and "Hospital (Approved Special)", in definition "Nursing facility (NF)", deleted "and Senior Services" following "Health", inserted "Title XXI Children's Health Insurance Program, which is known in New Jersey as NJ FamilyCare, and", inserted a comma following "beneficiaries" and "disabilities", and substituted "Medicaid/NJ FamilyCare" for "Medicaid"; and in definition "Outpatient hospital services", inserted a comma following "outpatient", substituted ". The institution shall be" for "and the institution is", and substituted "shall meet" for "meets" twice.

Annotations

Notes

Chapter Notes

Case Notes

No reimbursement for inpatient services provided while patient awaiting placement in skilled nursing care facility. *Monmouth Med. Center v. State, 158 N.J.Super. 241 (App.Div.1978)*, affirmed *80 N.J. 299 (1979)*, certiorari denied *444 U.S. 942 (1979)*.

Consent; bilateral salpingectomy and hysterectomy; purposes of Medicaid Reimbursement. Centra State Medical Center v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 65.

End of Document

N.J.A.C. 10:52-1.2A

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.2A (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:52-1.3* by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-1.3

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.3 Criteria for participation: outpatient hospital services

(a) The Division shall reimburse approved hospitals to provide covered outpatient hospital services, where applicable, in accordance with all the provisions of this chapter. In order to be approved and reimbursed as an outpatient hospital service, effective in accordance with the dates in (c) below, each site that provides an outpatient hospital service for which the hospital bills the Medicaid/NJ FamilyCare fee-for-service program as an outpatient hospital service shall have been approved by the Division in accordance with this rule. Such approval shall include sites located in the main inpatient hospital, and both the contiguous and non-contiguous sites.

(b) Each site shall meet all of the following criteria prior to receiving reimbursement from the Medicaid/NJ FamilyCare fee-for-service program as an outpatient hospital service, effective in accordance with the dates in (c) below:

1. The entity shall be physically located in close proximity to the hospital, and both the entity and the hospital shall service the same patient population (such as from the same service or catchment area);

i. In determining close proximity, the following factors will be considered:

(A) The distance between the entity and the inpatient hospital facility;

(B) The physical location (inner-city, urban, suburban or rural area) of the inpatient hospital facility and the entity; and

(C) The availability of other inpatient hospital facilities providing the same services located closer to the entity than the hospital requesting the outpatient designation.

ii. Pursuant to P.L. 2001, c.393, specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services shall not be subject to the close proximity criterion contained in (b)1 above. However, such pediatric facilities shall be subject to all other criteria set forth in (b)2 through 8 below.

2. The entity shall be an integral and subordinate part of the hospital, and as such, shall be operated with other departments of that hospital under the common hospital licensure issued by the New Jersey Department of Health, in accordance with *N.J.A.C. 8:43G*, or under the certification provisions of the appropriate State agency, in accordance with *N.J.A.C. 10:52-1.2*;

3. The entity shall be included under the accreditation of the hospital as specified by *N.J.A.C. 10:52-1.2* and that accrediting body shall have recognized the entity as part of the hospital;

4. The entity shall be operated under common ownership and control (such as common governance) by the hospital, as evidenced by the following:

i. The entity shall be subject to common bylaws and operating decisions of the hospital's governing body;

ii. The hospital shall have final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the entity; and

iii. The entity shall function as a department of the hospital with significant common resource usage of buildings, equipment and service personnel on a daily basis;

5. The entity director shall be under the direct day-to-day supervision of the hospital, as evidenced by the following:

i. The entity director or individual responsible for the day-to-day operations at the entity shall maintain a daily reporting relationship and be accountable to the chief executive officer of the hospital, and report through that individual to the governing body of the hospital; and

ii. Administrative functions of the entity, such as, but not limited to, records, billing, laundry, housekeeping, and purchasing shall be integrated with those of the hospital;

6. Clinical services of the entity and the hospital shall be integrated as evidenced by the following:

i. Professional staff of the entity shall have clinical privileges in the hospital;

ii. The medical director of the entity, if the entity has a medical director, shall maintain a day-to-day reporting relationship to the chief medical officer or similar official of the hospital;

iii. All medical staff committees or other professional committees at the hospital shall be responsible for all medical activities in the entity;

iv. Medical records for patients treated in the entity shall be integrated into the unified records system of the hospital;

v. Patients treated at the entity shall be considered patients of the hospital and have full access to all hospital services; and

vi. Patient services provided in the entity shall be integrated into corresponding inpatient and/or outpatient services, as appropriate, by the hospital;

7. The entity shall be held out to the public as a part of the hospital, such that patients shall know that they are entering the hospital and shall be billed accordingly; and

8. The entity and the hospital shall be financially integrated as evidenced by the following:

i. The entity and the hospital shall have an agreement for the sharing of income and expenses; and

ii. The entity shall report its costs in the cost report of the hospital using the same accounting system for the same cost reporting period as the hospital's.

(c) In order for a service provided at the site to be reimbursed as an outpatient hospital service, effective on the date indicated in (c)2 and 3 below, the following reporting requirements shall be met for approval by the Division:

1. If the location in which the services are provided is located in or contiguous to the main inpatient hospital, the Division shall assume that these outpatient hospital services meet the criteria for participation pursuant to (b) above; therefore, the reporting requirements in (c)2 and 3 below shall not be required for these services. However, even though the services are located contiguous to the main inpatient hospital, (d) below shall apply.

2. All hospitals with existing entities as defined in this section, which do not meet the requirements in (c)1 above, shall submit a report to the Division no later than October 15, 1997 indicating each location, the type of services provided, and how each entity meets the criteria for participation set forth in (b) above. The Division shall review each hospital's submission and determine whether or not the service provided at the entity is reimbursed appropriately as an outpatient hospital service in accordance with (b) above. A determination of and notification of the approval or denial for reimbursement as an outpatient hospital service shall be issued by the Division.

i. Pending the Division's review process, the entity shall be reimbursed at the interim rate, as specified by *N.J.A.C. 10:52-4.3(a)*.

ii. If the entity is approved to be reimbursed for a specific outpatient hospital service, the service shall continue to be reimbursed as an outpatient hospital service in accordance with *N.J.A.C. 10:52-4.3*, effective on the date of approval.

iii. If the entity is denied approval for reimbursement of a specific outpatient service, the reimbursement for that service as an outpatient hospital service shall be discontinued 20 days after the date on the determination letter. However, for services provided prior to the date that reimbursement as an outpatient hospital service is discontinued, adjustments shall be made to the cost report for entities that are not considered hospital-based, in accordance with *N.J.A.C. 10:52-4.3(a)*.

3. After September 15, 1997, all hospitals which intend to provide a new outpatient hospital service or existing service at a new location which is not contiguous to the inpatient hospital shall request and obtain approval from the Division before receiving Medicaid/NJ FamilyCare fee-for-service reimbursement as an outpatient hospital service.

i. The hospital shall report to the Division the location of each entity, the type of service provided, and how each entity meets the criteria for participation set forth in (b) above.

ii. The Division shall review each hospital's submission and determine whether or not the service provided by the entity shall be reimbursed as an outpatient hospital service. A determination of and notification of the approval or denial as an outpatient hospital service shall be issued by the Division and include the effective date of the notification of the approval or denial.

4. All information necessary, as specified in (c)3i above, for the Division to determine whether or not the services provided at the entity are approved as outpatient hospital services shall be sent to the following address:

Division of Medical Assistance and Health Services

Office of Hospital Reimbursement

PO Box 712, Mail Code #44

Trenton, New Jersey 08625-0712

5. In the event information is not submitted as required by (c)2 and 3 above, the service provided at the entity shall be neither approved nor reimbursed as an outpatient hospital service for services provided on or after September 15, 1997.

6. The Offsite Location (entity) Certification Form (FD-392) can be requested from the above address.

(d) Once the Division approves the entity to be reimbursed as an outpatient hospital service, the Division or its settlement agent, as specified in *N.J.A.C. 10:52-4.9*, shall ensure that the information submitted is in compliance with (b) above. A review may occur at any time at the Division's discretion, including, but not limited to, the time of the audit of the hospital's cost report. If it is determined that the service provided by the entity is not provided consistent with the criteria for participation, as specified in (b) above, the Division shall notify the hospital of its denial of the service and disallow the costs and the related reimbursement for any time that service or entity was not in compliance with these rules.

(e) Close proximity means the minimum distance between a hospital and an entity which will produce unduplicated services sufficient to meet the access and service needs of the population being served. The Division shall grant an exception to the close proximity requirement in (b)1 above on a case-by-case basis, if the exception provides access to the service by the population being served where access to the service has been limited. If an exception is granted for a specific service at an entity and that service changes, or the entity changes location, a hospital shall reapply for an exception. Requests for exceptions for entities existing prior to September 15, 1997 shall be sent to the Division in accordance with (c)2 above. A request for an exception for new entities attempting to be reimbursed as a hospital outpatient service after September 15, 1997 shall be sent to the Division in accordance with (c)3 above.

1. The following are examples of when the Division will grant an exception to the close proximity criterion stated in (b)1 above.

i. When access and/or availability to a particular service within a particular geographic area is limited; or

ii. When the availability of transportation to a particular service within a particular geographical area is limited.

(f) If the services provided at the entity are not approved by the Division as an outpatient hospital service, the entity may apply as a provider of another type of service to the Provider Enrollment Unit of the Division or the fiscal agent, as appropriate, consistent with N.J.A.C. 10:49-3 and 4, and the procedures for enrollment as indicated in the appropriate provider services manuals, such as for clinics, in *N.J.A.C. 10:66*, Independent Clinic Services, or in *N.J.A.C. 10:54*, Physician Services.

(g) If the hospital is not satisfied with the Division's determination, all appeals shall meet the requirements of the administrative hearing process in accordance with *N.J.A.C. 10:49-10.3*.

History

HISTORY:

New Rule, R.1997 d.396, effective September 15, 1997.

See: *29 N.J.R. 1003(a)*, *29 N.J.R. 4132(b)*.

Recodified from *N.J.A.C. 10:52-1.2A* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a) and (b), inserted references to NJ KidCare fee-for-service programs; and in (c)3, inserted a reference to NJ KidCare fee-for-service reimbursement. Former *N.J.A.C. 10:52-1.3*, Eligibility; claims procedures, recodified to *N.J.A.C. 10:52-1.4*.

Amended by R.2002 d.378, effective November 18, 2002.

See: *34 N.J.R. 2246(a)*, *34 N.J.R. 2549(b)*, *34 N.J.R. 3980(a)*.

Added (b)1ii.

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

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

In (a), substituted "FamilyCare" for KidCare" preceding "fee-for-service" and deleted "of Medical Assistance and Health Services "known as the "Division")," preceding "in accordance with this rule"; in (c), substituted "FamilyCare" for KidCare" preceding "fee-for-service" in 3, amended the address in 4 and added 6; in (d), amended the N.J.A.C. reference.

Public Notice: Moratorium on New or Relocated Hospital-Based Off-Site Clinic Services Applications.

See: *37 N.J.R. 3860(a)*.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (d), updated the N.J.A.C. reference.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a) and the introductory paragraph of (b), substituted "Medicaid/NJ" for "Medicaid or NJ"; in the introductory paragraph of (b), substituted "program" for "programs"; and in (b)2, deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

Case Notes

Division's interpretation of *N.J.A.C. 10:52-1.3(b)(7)* to require that an offsite outpatient hospital facility entitled to hospital-level rates be located in a building that is solely for the hospital facility was arbitrary, capricious, or unreasonable and constituted improper rulemaking in violation of *Metromedia, Inc. v. Director, Div. of Taxation, 97 N.J. 313 (1984)*. *N.J.A.C. 10:52-1.3(b)(7)* only requires that the entity be held out and appear to the public to be part of a hospital, and no regulation requires separate entrances or that the building be used solely for the hospital; signage and notices in and around the facilities, the size, layout, and the equipment in the facilities, as well as the hospital identification badges worn by the staff, sufficiently presented the entities to the public as being affiliated with the hospital. *Bacharach Physical Therapy v. DMAHS, OAL Dkt. Nos. HMA 2363-07 and HMA 2548-07, 2007 N.J. AGEN LEXIS 814*, Initial Decision (December 11, 2007).

N.J.A.C. 10:52-1.4

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.4 Use of PA-1C when applying for benefits for a hospital patient

(a) A hospital shall adhere to the following procedure for completing the form, the "Public Assistance Inquiry (PA-1C)" to inform the appropriate agency that an individual intends to file a Medicaid/NJ FamilyCare application:

1. For those aged, blind or disabled persons with limited income and resources who appear to be eligible for Supplemental Security Income (SSI)/ Medicaid, a hospital shall complete the form PA-1C and send it to the Social Security Administration (SSA) District Office serving their locale to initiate the eligibility process. The date of the inquiry shall protect the application date provided that the individual follows through with filing of an application.

2. For the aged, blind and/or disabled individuals, and/or pregnant women and/or children who do not qualify or who do not want an SSI money payment from the Social Security Administration and/or do want to be a Medicaid beneficiary through "Medicaid Only" or New Jersey Care . . . Special Medicaid Programs, a hospital shall complete the form PA-1C and send it to the appropriate county welfare agency (CWA).

3. A hospital shall submit the form PA-1C to the county welfare agency (CWA) immediately after the birth of a newborn of a mother who is or may become eligible for Medicaid/NJ FamilyCare. (Information on the newborn shall be included in item 1, 2, 3, 11a, and 15 only. The mother's signature shall be included in Item 22.)

i. There shall be no requirement for joint hospitalization of a mother and newborn as the sole condition for which claims for services to the newborn may be submitted using the mother's Person Number.

ii. With the exception of mothers receiving benefits through the Emergency Services for Aliens Program, a mother who is a Medicaid/NJ FamilyCare beneficiary and her newborn shall have the same Health Benefits Identification (HBID) Number when they are a part of the same household, but each shall be assigned his or her own Person Number. A mother receiving benefits through the Emergency Services for Aliens Program shall be assigned an HBID Number, and her newborn shall be assigned a separate HBID Number after being determined eligible in accordance with *N.J.A.C. 10:69* or 10:72, as applicable.

iii. A hospital shall be permitted to submit a claim for services to a newborn of a mother not enrolled in managed care for 60 days from the date of the birth through the end of the month in which the 60th day occurs or until the newborn is assigned his or her own Person Number, whichever happens first.

iv. After the extended time frame of 60 days from the date of birth through the end of the month in which the 60th day occurs or upon the assignment of the newborn's Person Number, the newborn's personal data shall be used on the claim form as soon as it is available to the hospital. The mother's personal data shall not be used on the claim form after this time frame or after the newborn's Person Number is available to the hospital.

4. Previously submitted PA-1C forms shall be updated by the hospital if subsequent facts emerge that alter the original referral.

i. When it is determined that the original referral to the Social Security Administration was incorrect, the hospital shall forward a copy of the original PA-1C to the CWA with a note of explanation (see also N.J.A.C. 10:49-2 in Administration for further information on Medicaid eligibility).

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.3* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted references to beneficiaries for references to recipients and substituted references to CBOSS for references to CWA throughout, and substituted a reference to Medicaid Eligibility Identification Numbers for a reference to HSP (Medicaid) Case Numbers in 3ii. Former *N.J.A.C. 10:52-1.4*, Eligibility of recipient for hospital services, recodified to *N.J.A.C. 10:52-1.5*.

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

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

In (a)3, substituted "3" for "4" and "22" for "23" in the introductory paragraph, rewrote ii and inserted "of a mother not enrolled in managed care" preceding "for 60 days" in iii.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a)2 and the introductory paragraph of (a)3, substituted "welfare agency (CWA)" for "board of social services (CBOSS)"; and in (a)4i, substituted "CWA" for "CBOSS".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a) and of (a)3, and in (a)3ii, substituted "Medicaid/NJ FamilyCare" for "Medicaid"; in the introductory paragraph of (a)3, inserted a comma following "11a"; and in (a)3ii, substituted "Health Benefits Identification (HBID)" for the first occurrence of "Medicaid Eligibility Identification", substituted "an HBID" for "a Medicaid Eligibility Identification", and substituted the second occurrence of "HBID" for the third occurrence of "Medicaid Eligibility Identification".

Annotations

Notes

Chapter Notes

§ 10:52-1.4 Use of PA-1C when applying for benefits for a hospital patient

End of Document

N.J.A.C. 10:52-1.5

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.5 Eligibility of beneficiary for hospital services

(a) Hospital services shall not be reimbursed by the Medicaid/NJ FamilyCare fee-for-service program when hospital services were rendered prior to or after the period of beneficiary eligibility, as determined in accordance with *N.J.A.C. 10:49-2.7*; except that, when a Medicaid/NJ FamilyCare beneficiary in an acute care general hospital loses eligibility during an inpatient hospital stay, but was eligible on the date of admission, eligibility shall continue for hospital inpatient services for the entire length of that hospital stay.

(b) When a patient is admitted to a hospital and is determined Medicaid/NJ FamilyCare eligible subsequent to the date of admission, charges incurred during the ineligible period of the hospital stay shall not be reimbursable, unless coverage is pursued and approved under retroactive eligibility.

(c) For coverage of services rendered prior to date of application for Medicaid/NJ FamilyCare, the beneficiary shall apply for retroactive eligibility, in accordance with *N.J.A.C. 10:49-1.1*.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.4* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted references to beneficiaries for references to recipients throughout; and in (a), inserted a reference to NJ KidCare fee-for-service programs, and changed N.J.A.C. reference. Former *N.J.A.C. 10:52-1.5*, Covered Services (Inpatient and Outpatient), recodified to *N.J.A.C. 10:52-1.6*.

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

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

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service" and substituted "prior to or after the period" for "prior to and after period" preceding "of beneficiary eligibility".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; and in (a), substituted "program" for "programs".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-1.6

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.6 Covered services (inpatient and outpatient)

(a) The Division will cover those inpatient services ordinarily furnished by an approved hospital maintained for the treatment and care of patients, and provided to any Medicaid/NJ FamilyCare fee-for-service beneficiary, for whom professionally developed criteria and standards of care were used to determine that the beneficiary warranted an appropriate hospital level of care for a given diagnosis or problem.

1. Inpatient psychiatric services in approved beds in a general hospital for patients of any age shall be covered services.

2. Inpatient room and board service shall be provided in a semi-private accommodation. Accommodations other than semi-private require certification of medical necessity or lack of availability of semi-private accommodations.

3. Inpatient services in an acute general hospital rendered the day after acute care is no longer medically necessary shall be covered only under specified conditions. (See Social Necessity Days in *N.J.A.C. 10:52-1.14* and Administrative Days in *N.J.A.C. 10:52-1.9*.)

4. Non-physician services, supplies, and equipment supplied by an outside vendor to Medicaid/NJ FamilyCare beneficiaries who are receiving inpatient acute care hospital services shall be covered directly under the hospital reimbursement system. Vendor claims for these services are the responsibility of the acute care hospital where the beneficiary is a patient and shall not be billed directly to the Medicaid/NJ FamilyCare fiscal agent.

5. For beneficiaries in the Medically Needy Program, inpatient hospital services shall be available only to pregnant women. For information on how to identify a Medicaid beneficiary in the Medically Needy Program, refer to *N.J.A.C. 10:49-2.3(c)*, Administration.

(b) The Division shall pay for eligible ancillary services provided during a non-covered period in an acute care hospital for the following situations:

1. When the Utilization Review Organization (URO) denies the entire admission for acute level of care; or

2. When the URO certifies the admission as acute but "carves out" days from the approved continued stay. For eligible ancillary services that were provided during days that were "carved out" or "non-covered" and occurring in an inlier stay, no additional reimbursement by Medicaid/NJ FamilyCare fee-for-service shall be made, because the services are already included in the DRG reimbursement rate; or

3. When the URO certifies that only part of the stay is acute.

(c) Medically necessary inpatient psychiatric services provided in an approved private psychiatric hospital shall be covered by the Division for any Medicaid/NJ FamilyCare beneficiary age 65 or older; or for any other Medicaid/NJ FamilyCare-Children's Program beneficiary before reaching the age of 21, except that a Medicaid/NJ FamilyCare beneficiary receiving the services immediately before attaining age 21 may

continue to receive the services until they are no longer needed or until the beneficiary reaches age 22, whichever occurs first.

(d) Outpatient services include those medically necessary items or services (preventive, diagnostic, therapeutic, rehabilitative, or palliative) provided to an outpatient, by or under the direction of a physician or dentist, except for the supervision of certified nurse midwife services, pursuant to the rules of the Division, State and applicable Federal regulations, including those services listed below:

1. Outpatient psychiatric services in general hospitals and private psychiatric hospitals for patients of all ages;

2. Same day surgery shall be:

i. Identified on the UB-92 claim form as a 131 or 136 bill type in accordance with *N.J.A.C. 8:31B-3.11(a)*1;

ii. The patient shall be discharged before midnight of the day of admission so the admission date and discharge date are the same;

iii. The patient shall have had surgery performed in a fully equipped operating room, for example, one routinely equipped and capable of providing general anesthesia, and identified by an operating room charge on the claim; and

iv. The patient shall have had a normal discharge, for example was not transferred, did not leave "against medical advice," and was not discharged dead. (See *N.J.A.C. 8:31B-3.11* Same day surgery.)

3. Physician services in hospitals (that is, specifically unbundled physicians): A physician practicing in a hospital out-patient department whose reimbursement is not part of the hospital's cost may bill fee-for-service if the arrangement with the hospital permits it.

(e) Transfer from one outpatient facility to another outpatient facility, or a change from an outpatient facility to a private practitioner's care is allowable; however, effort shall be made to avoid duplication of diagnostic tests or services.

(f) For policies and procedures for Ambulatory Surgical Centers, see *N.J.A.C. 10:52-2.1* and N.J.A.C. 10:66-5, Independent Clinic Services.

(g) For policies and procedures for hospital-affiliated home health agencies, see *N.J.A.C. 10:52-2.6* and *N.J.A.C. 10:60*, Home Care Services.

(h) For policies and procedures for Medical Day Care Centers (Hospital Affiliated), see *N.J.A.C. 10:52-2.7* and *N.J.A.C. 8:86*, Adult Day Health Services.

(i) For policies and procedures for HealthStart (Comprehensive Maternity and Pediatric Care Services), see N.J.A.C. 10:52-3. For policies and procedures for Early and Periodic Screening Diagnostic and Treatment, see *N.J.A.C. 10:52-2.4*.

(j) For other policies and procedures related to specific services, both inpatient and outpatient, see N.J.A.C. 10:52-2.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.5* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted references to beneficiaries for references to recipients throughout; in (a), inserted a reference to NJ KidCare fee-for-service beneficiaries in the introductory paragraph, changed N.J.A.C. references in 3 and 5, and inserted a reference to NJ KidCare fiscal agents in 4; in (b)2, inserted a reference to NJ KidCare--Plan A, B, or C fee-for-service; in (c), inserted a reference to NJ KidCare beneficiaries; rewrote (d); and in (g) through (i), changed N.J.A.C. references. Former *N.J.A.C. 10:52-1.6*, Disproportionate share of adjustments, recodified to *N.J.A.C. 10:52-1.7*.

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

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

Rewrote the section.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a)5, updated the N.J.A.C. reference; and in (h), substituted "Adult Day Health" for "Medical Day Care".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; and in (a)4, inserted a comma following "supplies".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-1.7

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.7 Offset of disproportionate share hospital payments

The Division shall, upon receipt of documentation from the Department of Health, apply an offset to a hospital's disproportionate share hospital Medicaid/NJ FamilyCare payments to collect delinquent statutory and regulatory debts owed by the hospital to the State arising under the Health Care Facilities Planning Act, *N.J.S.A. 26:2H-1* et seq., and the implementing regulations.

History

HISTORY:

New Rule, R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.6*, Non-Covered Services (Inpatient and Outpatient), recodified to *N.J.A.C. 10:52-1.7*.

Recodified from *N.J.A.C. 10:52-1.6* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Former *N.J.A.C. 10:52-1.7*, Non-Covered Services (Inpatient and Outpatient), recodified to *N.J.A.C. 10:52-1.8*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted "and Senior Services" following "Health", and substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

§ 10:52-1.7 Offset of disproportionate share hospital payments

End of Document

N.J.A.C. 10:52-1.8

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.8 Non-covered services (inpatient and outpatient)

(a) The following non-covered services (inpatient and outpatient) shall not be eligible for payment by the Division:

1. Hospital admissions of the following description:

i. Admission for any condition for which hospitalization is not medically necessary;

ii. Admission primarily for rest cure, custodial care, convalescent care or diet therapy for exogenous obesity;

iii. Admission for illnesses which, according to generally accepted professional standards, are not amenable to favorable modification. However, psychiatric services in a general hospital shall be covered for the purpose of determining that such disorders or illness (such as senility) are not amenable to favorable modification;

iv. Admission for diagnostic procedures which may be done on an out-of-hospital basis including, but not limited to, laboratory tests, electrocardiograms and diagnostic radiological services;

v. Admission or extension of hospital stay solely for research or teaching studies;

vi. Admission for inpatient services provided in an approved private psychiatric hospital unless:

(1) The Medicaid beneficiary is age 65 or over;

(2) The Medicaid beneficiary has not attained age 21, except that a beneficiary who is receiving such services immediately preceding the date on which he or she attained age 21 will continue to be covered until the date the individual no longer requires such services or the date the individual reaches age 22, whichever occurs first;

(3) The NJ FamilyCare-Plan A beneficiary has not attained the age of 21; or

(4) The FamilyCare-Children's Program-Plan B, C or D beneficiary has not attained the age of 19; and

vii. Admission of beneficiaries in the Medically Needy Program, except for pregnant women. For information on how to identify a Medically Needy beneficiary, see *N.J.A.C. 10:49-2.3(c)*, Administration.

2. Any service or item requiring prior authorization (see *N.J.A.C. 10:52-1.10*, Prior authorization) which has been performed without prior authorization.

3. Medically unnecessary items and services, as follows:

i. Any service or item which is not medically necessary for the prevention, diagnosis, palliation, rehabilitation or treatment of a disease, injury or condition;

ii. Inpatient hospital services rendered prior to the day it is medically necessary for the diagnostic services or surgical or medical treatment for which the patient is admitted.

iii. Inpatient hospital services rendered in a general hospital at any time following the day that such services are no longer medically necessary, except when special circumstances, that is, "social necessity," exist which prevent the discharge or transfer of the patient or when an inpatient is eligible for "administrative days" (see *N.J.A.C. 10:52-1.14*, Social Necessity and *N.J.A.C. 10:52-1.9*, Administrative Days).

iv. Inpatient hospital services denied for lack of medical necessity shall not be covered.

4. Private duty nursing services in the hospital inpatient setting;

5. Research or Teaching Studies;

6. Surgery (Elective), as follows:

i. Cosmetic Surgery, except that the Division shall consider authorization of a request from the patient's physician for elective cosmetic surgery, if a significant redeeming medical necessity can be demonstrated; and,

ii. Second Opinion Elective Procedures without meeting the Second Opinion requirement (see *N.J.A.C. 10:52-1.13* Second Opinion Program);

7. Transportation, except as in *N.J.A.C. 10:52-2.16* Transportation-Services (Hospital-based);

8. Fee-for-service billed by a hospital-based physician who is salaried and whose services are reimbursed as part of the hospital's cost;

9. Other services and items not directly related to the care of the patient, such as:

i. Inpatient items and services including guest meals and accommodations, television, telephone, and similar items and services. Personal items shall be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items; and,

ii. Outpatient items and services which are not usually part of the outpatient service; for example, eyeglasses, custom-made limbs and braces, or surgical supplies.

10. Services and items that are billed by, and payable to, another vendor;

11. Services and items furnished by the hospital, for which the hospital does not normally charge;

12. Services and items not medically required for the diagnosis or treatment of a disease, injury or condition; and,

13. Services provided to a patient during the same period for the same condition by both private practitioner and outpatient facility, or by two different facilities, shall not be covered. Payment shall be made for only one service, except in a medical emergency. (For definition of a medical emergency, see *N.J.A.C. 10:49-6.1(a)*2.)

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.6* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.7*, Administrative Days (Nursing Facility Level of Care)--General, Special (Classification A & B) and Private Psychiatric Hospitals, recodified to *N.J.A.C. 10:52-1.8*.

Recodified from *N.J.A.C. 10:52-1.7* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted references to beneficiaries for references to recipients and changed N.J.A.C. references throughout, inserted 1vi(3), deleted a former 9, and recodified former 10 through 14 as 9 through 13. Former *N.J.A.C. 10:52-1.8*, Administrative Days (Nursing Facility Level of Care)--General, Special (Classification A & B) and Private Psychiatric Hospitals, recodified to *N.J.A.C. 10:52-1.9*.

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

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

In (a), rewrote the introductory paragraph, substituted "a beneficiary who is" for "an individual" preceding "receiving such services" in 1iv(2), added a new 1iv(3), recodified former 1iv(3) as 1iv(4) and rewrote the paragraph, deleted "and/" following "diagnostic services" in 3ii, rewrote 3iii and amended the N.J.A.C. reference in 7.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a)13, substituted "a medical" for "an" twice, updated the N.J.A.C. reference, and deleted ", Administration" from the end.

Annotations

Notes

Chapter Notes

Case Notes

No reimbursement for inpatient services provided while patient awaiting placement in skilled nursing care facility. *Monmouth Med. Center v. State, 158 N.J.Super. 241 (App.Div.1978)*, affirmed *80 N.J. 299 (1979)*, certiorari denied *444 U.S. 942 (1979)*.

ALJ rejected an insurer's denial of an insured's request for outpatient sacroiliac joint surgery because the proposed surgery was not within the scope of Uniform Medical Policy #139 despite the insurer's claims to that effect. The medical records supported a finding that the treatment would be medically necessary and was directly related to an automobile accident in which the insured was injured. *M.A. v. Horizon NJ Health, OAL DKT. NO. HMA 17596-16, 2017 N.J. AGEN LEXIS 103*, Initial Decision (February 16, 2017).

N.J.A.C. 10:52-1.9

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

§ 10:52-1.9 Administrative days (nursing facility level of care)--general, special (Classification A & B) and private psychiatric hospitals

(a) For a patient who is no longer in need of inpatient acute level of care and who is awaiting placement in a nursing facility, payment shall be made for "administrative days" if the general, special, rehabilitation, or the private psychiatric hospital is able to demonstrate the following:

1. All other possible health insurance benefits have been utilized;

2. Discharge planning was initiated upon admission of the patient to the hospital and was reviewed and updated regularly;

3. Within one working day of identifying a Medicaid/NJ FamilyCare-Plan A beneficiary as being at risk for nursing facility placement, the hospital notified the Medical Assistance Customer Center (MACC), CWA, and the Office of Community Choice Options (OCCO). See *N.J.A.C. 10:52-1.11*, Preadmission screening for nursing facility placement; and

4. The care and services provided are medically necessary, that is, the attending physician wrote a discharge order from acute care or made a written entry in the medical record that the patient could be transferred to a nursing facility (NF), a Preadmission Screening Evaluation (PAS) confirmed the necessity for nursing facility services and placement could not be made in a NF, as substantiated by documentation of timely and continuous contact (at a minimum, twice a week) with family members, nursing facilities (NFs), and placement agencies.

(b) Upon satisfaction of all the conditions listed under (a)1 through 4 above, payment will be made at the statewide weighted average per diem rate paid to Medicaid participating NFs, as determined on January 1 of each year;

(c) *N.J.S.A. 30:4D-6.7* and 6.8 require every nursing facility in the State to reserve a Medicaid beneficiary's bed for up to 10 days when the beneficiary is transferred from the nursing facility to a general or private psychiatric hospital. This requirement is applicable to NJ FamilyCare-Plan A beneficiaries also. If the discharged Medicaid or NJ FamilyCare-Plan A beneficiary is unable to return to the nursing facility before the end of the 10-day period, the discharged beneficiary shall have priority for the next available Medicaid bed in the facility. When the beneficiary is admitted to the hospital under the bed reserve policy, the hospital shall:

1. Involve the NF in the preparation of the hospital's discharge planning;

2. Advise the NF of an anticipated discharge date;

3. Keep the NF informed of the patient's progress, particularly if something unexpected happens which causes a revision to the discharge plan; and

4. Give the NF as much advanced notice as possible to prepare for the return of the patient.

(d) When the 10-day bed reserve is exceeded and no bed is available in the NF from which the beneficiary was transferred, the hospital shall provide the level of NF care determined appropriate by the Department

of Human Services' Division of Aging Services (DoAS)-designated professional staff during the Preadmission Screening Evaluation and authorization until such time as a NF bed is available to the Medicaid/NJ FamilyCare-Plan A beneficiary. (See *N.J.A.C. 10:52-1.11*.)

(e) For the information of hospital staff assisting in the discharge of a patient to an NF, *N.J.S.A. 30:4D-17.3* prohibits, in general, a NF from requiring private pay contracts or donations under certain conditions on behalf of Medicaid beneficiaries. To enforce this prohibition, the law establishes both criminal and civil penalties.

(f) *N.J.S.A. 10:5-12.2* of the New Jersey Civil Rights Act prohibits a NF from discriminating against Medicaid eligible persons and beneficiaries of municipal general assistance by denying them admission when the NF's Medicaid occupancy level is below the Statewide occupancy level.

(g) Provisions for reimbursement of administrative days (nursing facility level of care) shall not apply to special hospitals (Classifications A and B).

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.7* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.8*, Prior Authorization, recodified to *N.J.A.C. 10:52-1.9*.

Recodified from *N.J.A.C. 10:52-1.8* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted references to beneficiaries for references to recipients throughout; in (a), rewrote 2; in (c), inserted a new second sentence, and inserted a reference to NJ KidCare--Plan A beneficiaries in the third sentence in the introductory paragraph; rewrote former (c)5 as (d); recodified former (d) through (f) as (e) through (g); and in the new (e), deleted a former third sentence. Former *N.J.A.C. 10:52-1.9*, Prior authorization, recodified to *N.J.A.C. 10:52-1.10*.

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

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

Rewrote (a); in (c), rewrote the introductory paragraph; rewrote (d).

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a)3, substituted "CWA" for "CBOSS".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a), inserted a comma following "rehabilitation"; in (a)3 and (d), substituted "Medicaid/NJ" for "Medicaid or NJ"; in (a)3, inserted a comma following "CWA" and following the N.J.A.C. cite; and in (d), substituted "Human Services' Division of Aging Services (DoAS)-designated" for "Health and Senior Services-designated", and inserted "and authorization".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-1.10

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.10 Prior authorization

(a) Prior authorization shall be required for certain dental procedures (see *N.J.A.C. 10:56*, Dental Services) and partial hospitalization provided in the outpatient department of an acute care hospital beyond exempt time frames (see *N.J.A.C. 10:52-2.10(d)* and (e)).

(b) Other services require adherence to special procedures, such as the requirements of the Second Opinion Program, before certain elective surgical procedures are performed. Specific services are described in the "Policies and Procedures for Providing Specific Services" in N.J.A.C. 10:52-2. Hospital entitlement to Medicaid/NJ FamilyCare reimbursement is subject to providing these services in accordance with the policies and procedures as outlined in N.J.A.C. 10:52-2. For general information about prior and retroactive authorization, see *N.J.A.C. 10:49-6.1*, Administration.

(c) For out-of-State services, see *42 CFR 431.52*. Prior authorization as outlined in (d) below shall be required for inpatient and outpatient hospital services provided to a beneficiary outside the State of New Jersey, except as provided in (e) below. Hospital covered services for a beneficiary with an Eligibility Identification Number with the 1st and 2nd digits of 90 or the 3rd and 4th digits of 60, residing out-of-State at the discretion of the New Jersey Department of Human Services, shall not require prior authorization. However, any covered service that requires prior authorization as a prerequisite for payment to New Jersey Medicaid/NJ FamilyCare providers also requires prior authorization if it is to be reimbursed by the Division in any other state, except that prior authorization is not required for emergency and interstate transfers.

(d) A request for authorization for reimbursement for out-of-State services shall be directed to the Medical Assistance Customer Center (MACC) in the area where the beneficiary resides except as listed in (d)1 below. For a listing of MACCs, see the Directory at *N.J.A.C. 10:49*, Appendix, Form 13 or online at: *http://www.state.nj.us/humanservices/dmahs/info/resources/macc/index.html*.

1. Requests for prior authorization of out-of-State psychiatric services shall be directed to the Division of Medical Assistance and Health Services, Mental Health Unit, Office of Utilization Management, PO Box 712, Mail Code #18, Trenton, NJ 08625-0712.

i. For beneficiaries under age 18 and those individuals who are over the age of 18 and under the age of 21 who were receiving mental/behavioral health services through the Department of Children and Families (DCF) and/or the DCF Children's System of Care prior to their 18th birthday, requests for prior authorization of out-of-State psychiatric services shall be coordinated by the Care Management Organization (CMO) or other authorized entity coordinating the beneficiary's mental/behavioral health services and shall be directed by that entity to the DCF Contracted Systems Administrator (CSA). As part of the coordination of inpatient out-of-State psychiatric hospital services for these beneficiaries, the CMO and/or CSA shall direct requests for prior authorization for these services to the DMAHS in accordance with (d)1 above.

2. For a beneficiary who resides in New Jersey in other than a hospital and who is to be admitted or referred to an out-of-State hospital for elective inpatient or outpatient services, the physician planning such action shall sign a statement that the medically necessary service is not available at a reasonable distance within the State of New Jersey; and

3. For a beneficiary who is traveling outside New Jersey and who is to be admitted to an out-of-State hospital for elective surgery, the attending physician shall justify by a signed statement that an attempt to return to a New Jersey hospital would create a significant risk to life or health or would create the need for an unreasonable amount of travel for the beneficiary.

4. The Division shall notify, in writing, the physician making the request.

i. If authorized, the authorization letter of the Medical Consultant of the Division shall be forwarded to the requesting physician. When arranging for hospital admission, the physician shall forward a copy of the authorization letter to the hospital. When submitting the claim for services to the fiscal agent, the hospital shall attach the authorization letter, or a copy of the letter, to the claim.

(e) Prior authorization shall not be required for emergencies nor for interstate hospital transfers. However, in these instances, the hospital shall attach the attending physician's signed statement to the claim, attesting to the nature of the emergency or, for a hospital interstate transfer, attesting to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey.

(f) For Medicaid/NJ FamilyCare beneficiaries who have the diagnosis of Head Injury, for whom it is medically necessary to discharge the beneficiary from a hospital or special hospital to a special care nursing facility (SCNF), or to home care through enrollment into Managed Long-Term Supports and Services (MLTSS) under the New Jersey 1115 Comprehensive Medicaid Waiver (the Comprehensive Waiver), the hospital discharge planner or social worker shall obtain prior authorization for the placement (for either in-State or out-of-State patients) from the Medicaid/NJ FamilyCare MCO for enrollment into MLTSS. For information on MLTSS, see *N.J.A.C. 10:60*.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.8* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.9*, Pre-Admission screening for nursing facility (NF) placement, recodified to *N.J.A.C. 10:52-1.10*.

Recodified from *N.J.A.C. 10:52-1.9* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted references to beneficiaries for references to recipients throughout; in (a) and (f), changed N.J.A.C. references; in (b), substituted a reference to Medicaid and NJ KidCare reimbursement for a reference to Medicaid payment; and in (c), substituted a reference to Eligibility Identification Numbers for a reference to HSP (Medicaid) Case Numbers. Former *N.J.A.C. 10:52-1.10*, Pre-Admission screening for nursing facility (NF) placement, recodified to *N.J.A.C. 10:52-1.11*.

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

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

In (b), substituted "FamilyCare" for "KidCare" preceding "reimbursement" and inserted "in N.J.A.C. 10:52-2" following "procedures as outlined"; in (d), substituted references to MACCs for references to MDOs throughout the introductory paragraph and rewrote 1; rewrote (f).

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a), updated the N.J.A.C. reference; in the introductory paragraph of (d), deleted "the end of the" following "Directory at", substituted "Appendix, Form 13 or online at: *http://www.state.nj.us/humanservices/dmahs/info/resources/macc/index.html*" for "Administration"; in (d)1, inserted "Division of Medical Assistance and Health Services,"; added (d)1i; and in (f), updated the N.J.A.C. references, and deleted "Administration" from the end.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; in (c), substituted "outlined" for "out-lined", and substituted "state" for the fourth occurrence of "State"; in (d)1i, substituted "Children's System of Care" for "Division of Child Behavioral Health Services (DCBHS)", and inserted "(CMO)"; and rewrote (f).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-1.11

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.11 Preadmission screening for nursing facility (NF) placement

(a) The Department of Health and Senior Services is the agency responsible for administering the Preadmission Screening Program. The following is provided to hospitals so that they understand the process and the rules a hospital shall follow to ensure Medicaid or NJ FamilyCare-Plan A reimbursement for the care of individuals whose discharge planning includes placement into a nursing facility.

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

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared during the Preadmission Screening (PAS) process. The HSDP reflects the individual's current or potential problems, required care needs, the need for Preadmission Screening and Resident Review (PASRR) and the Track of Care.

"Level I PASRR screen" means the process of identification of an individual meeting the criteria for serious mental illness (MI) or mental retardation (MR) or both, as described throughout this section, and determining whether the individual also meets the NF level of care requirements.

"Level II PASRR evaluation" means the process of evaluating and determining whether an individual meets NF level of care, and determining whether an individual needs specialized services for MI or MR or both. An individual who requires specialized services cannot receive those services in a NF.

"Preadmission screening (PAS)" means that process by which all Medicaid eligible beneficiaries seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF, receive a comprehensive needs assessment by professional staff designated by the Department of Health and Senior Services to determine their long-term care needs and the most appropriate setting for those needs to be met, pursuant to *N.J.S.A. 30:4D-17.10*. (P.L. 1988, c.97.)

"Preadmission Screening and Resident Review (PASRR)" means that process by which all individuals meeting the clinical criteria for mental illness (MI) or mental retardation (MR), regardless of payment source, are screened prior to admission to an NF in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition. PASRR includes two levels, Level I PASRR screen and Level II PASRR evaluation, as defined above and described in this section.

"Professional staff designated by the Department of Health and Senior Services (DHSS professional staff)" means a nurse licensed or certified in accordance with *N.J.A.C. 13:37* or a social worker who performs health needs assessments and care management counseling in accordance with this section.

"Specialized Services for Mental Illness (MI)" means those services that are determined to be medically indicated when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based upon a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24-hour supervision of the individual, specific therapies and activities are prescribed, with the following objectives: to diagnose and reduce behavioral symptoms; to improve independent functioning; and as early as possible, to permit functioning at a level where less than Specialized Services are appropriate. Specialized Services go beyond the range of

services that an NF is authorized to provide and can only be provided in a 24-hour inpatient psychiatric setting.

"Specialized Services for Mental Retardation (MR)" means those services required when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24-hours per day, to teach the individual functional skills. Specialized Services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is authorized to provide.

"Track of care" means designation of the setting and scope of Medicaid/NJ FamilyCare-Plan A services as determined by the PAS process. The PAS is conducted by the professional staff designated by the Department of Health and Senior Services (DHSS) following an assessment of the Medicaid or NJ FamilyCare-Plan A beneficiary or potential Medicaid or NJ FamilyCare-Plan A beneficiary, as follows:

1. "Track I" means long-term NF care;

2. "Track II" means short-term NF care; and

3. "Track III" means long-term care services in a community setting.

(c) Preadmission screening (PAS) authorization shall be required prior to admission to a Medicaid certified NF of a Medicaid or NJ FamilyCare-Plan A beneficiary, or an individual who may become a Medicaid or NJ FamilyCare-Plan A beneficiary within six months following placement in a Medicaid certified NF. If the NF applicant has received psychiatric inpatient care for a year or more, a PASRR shall be performed, in addition to the PAS, prior to admission. Professional staff designated by DHSS shall assess each individual's care needs and determine the appropriate setting for the delivery of needed services. Professional staff designated by DHSS will authorize or deny NF placement based on the clinical eligibility requirements at *N.J.A.C. 8:85-2.1* and the feasibility of alternative placement and will designate the track of care, in accordance with *N.J.A.C. 8:85-1.8*.

(d) PAS authorization is also required for individuals identified as having a serious MI or MR regardless of the payment source. The PASRR assessment and authorization process shall be subsumed within the State's PAS protocols, as required by (e) below.

1. A Level I PASRR screen shall be required for individuals suspected of, or diagnosed as having serious MI, MR, or both or related conditions.

2. An individual is considered to have a serious mental illness (MI) if he or she has a mental illness, such as schizophrenia, mood disorder, paranoia, panic or severe anxiety disorder, or similar condition found in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR 2000 edition) (available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22269-3901 and *www.psych.org*) that leads to a chronic disability and that meets the PASRR requirements for diagnosis, level of impairment and duration of illness.

i. An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR 2000 edition) and does not have a serious mental illness.

3. An individual is considered to have mental retardation (MR) if he or she has a level of retardation (mild, moderate, severe or profound) described in the "American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983)" or a related condition, as defined by, and pursuant to, Section 1905(d) of the Social Security Act (Omnibus Budget Reconciliation Act of 1987 P.L. 100-203); *42 U.S.C. § 1396(d)*, and (d)3i below. An individual with a diagnosis of MR or a related condition and a diagnosis of dementia shall receive a Level II PASRR screen prior to admission to a Medicaid certified nursing facility.

i. "Persons with related conditions" means individuals who have a severe and chronic disability that meets all of the following conditions:

(1) The person has a diagnosis of mental retardation (MR) or other developmental disability, such as cerebral palsy, epilepsy, autism, spina bifida or other neurological impairment; and

(2) The person has a history or past records which show that the onset of the mental retardation or related conditions occurred prior to age 22.

4. A Level II PASRR evaluation shall be conducted for mentally ill or mentally retarded individuals only if the assessment performed by the professional staff designated by DHSS results in authorization of NF placement.

i. A Level II PASRR evaluation for individuals with serious MI requires that a psychiatric examination be performed by a Board eligible/certified psychiatrist or APN certified in mental health to determine the need for specialized services, in accordance with (e) below. When all reasonable efforts to secure a psychiatrist fail, an M.D. or D.O. who is not a psychiatrist may perform the examination.

ii. A Level II PASRR evaluation for MR individuals will be performed by the Division of Developmental Disabilities (DDD) to determine the need for specialized services, in accordance with (e) below.

5. Hospitals shall not transfer an individual requiring a Level II PASRR evaluation to Medicaid-certified NFs until the Level II PASRR has been conducted and the hospital has received a Department of Health and Senior Services Office of Community Choice Options letter of approval indicating that the individual does not require specialized services.

6. For individuals diagnosed with Alzheimer's or related dementias, documentation to support the diagnosis, including the history, physical examination and diagnostic workup shall be provided to the admitting Medicaid certified nursing facility for the individual's clinical record.

7. After an initial PASRR process has been completed, the individual transferred from a nursing facility to an acute care general hospital or an individual with serious MI being transferred to a psychiatric hospital for less than one year shall not require a Level I PASRR screen or a Level II PASRR evaluation prior to transfer back to a nursing facility. If the individual is transferred to a different facility, the hospital discharge planner shall advise the admitting NF of the individual's former NF placement.

(e) The determination of the necessity for NF level of care shall be performed through Preadmission Screening (PAS), as mandated by *N.J.S.A. 30:4D-17.10*. Professional staff designated by DHSS shall determine the necessity for NF level of care for Medicaid and NJ FamilyCare-Plan A beneficiaries, for individuals who may become Medicaid and NJ FamilyCare-Plan A beneficiaries within six months following admission to a Medicaid certified facility, and for individuals identified as meeting PASRR Level I criteria. The Office of Community Choice Options (OCCO) having jurisdiction for the area where an acute care hospital is located has the responsibility for completing the PAS assessment regardless of the beneficiary's county of residence or anticipated county of discharge. A listing of the Offices of Community Choice Options can be obtained by writing to the Director, Division of Aging and Community Choice Options, Department of Health and Senior Services, PO Box 807, Trenton, New Jersey 08625-0807, or by accessing the DHSS Division of Consumer Support website at *www.state.nj.us/health/consumer/directory.htm*, or by accessing the fiscal agent website at *www.njmmis.com* and clicking on the "Frequently Asked Questions" tab.

1. Professional staff designated by DHSS will review the medical, nursing and social information obtained at the time of assessment, as well as any other supporting data, in order to assess the individual's care needs and determine the appropriate setting for the delivery of needed services. The professional staff designated by DHSS will authorize or deny NF placement based on the clinical eligibility requirements found at *N.J.A.C. 8:85-2.1* and the feasibility of alternative placement. Professional staff designated by DHSS will also designate the track of care.

i. If alternative care is available, accessible and appropriate to the needs of the individual, the request for NF placement will be denied.

ii. If an appropriate alternative placement becomes available and accessible for a person already approved for NF care and awaiting placement, the authorization for NF placement will be rescinded.

iii. The professional staff designated by DHSS will advise the hospital discharge planner or social worker of the NF level of care approval and the setting for the delivery of needed services. If the individual requires a Level II PASRR evaluation, a letter will be given to the individual advising him or her that the Level II PASRR evaluation must be completed prior to admission to the NF.

2. The professional staff designated by DHSS will schedule and perform the assessment process within three working days of the hospital discharge planner or social worker's initial contact with the OCCO. Individuals who exhibit unstable, severe medical conditions, such as a patient in the Intensive Care or Coronary Care Unit or a patient who is awaiting surgery, shall not be referred for PAS until that condition has stabilized.

3. A signed Release of Information form shall be obtained from the potentially Medicaid-eligible patient. If the patient refuses NF placement, home care services, or participation in the PAS assessment process, the professional staff designated by DHSS will make every effort to obtain a signed participation declination statement, which will be included in the patient's OCCO case record.

4. NF placement approval: The professional staff designated by DHSS will verbally advise the hospital discharge planner or social worker and patient or legal representative of the assessment decision.

i. For a Track I or II determination, the professional staff designated by DHSS will leave a copy of the HSDP and signed approval letter with the discharge planner or social worker. For individuals requiring a Level II PASRR evaluation, the signed approval letter and HSDP shall be forwarded only after the determination has been made that no specialized services are required.

ii. For a Track III determination, the professional staff designated by DHSS will leave a copy of the HSDP with the discharge planner or social worker to forward to the home care provider. The discharge planner or social worker shall arrange needed home health services and forward a copy of the HSDP to the home care agency. A Track III determination shall not be an authorization for NF services.

iii. The original approval letter signed by the professional staff designated by DHSS will be sent by the OCCO to the individual or his or her legal representative with copies to the county welfare agency (CWA).

iv. A copy of the HSDP must be attached to the hospital discharge material and forwarded with the patient to the admitting NF.

(1) If the patient being transferred will be eligible for Medicare benefits, the transfer shall be made to a Medicare/Medicaid participating NF.

5. NF placement denial: The professional staff designated by DHSS will verbally advise the hospital discharge planner or social worker and patient or the patient's legal representative of the assessment decision. The professional staff designated by DHSS will leave a signed copy of the NF placement denial letter with the discharge planner or social worker. The original denial letter, signed by the professional staff designated by DHSS, will be sent to the patient or the patient's legal representative by the OCCO, with copies to the county welfare agency (CWA).

(f) The hospital discharge planner or social work staff shall be responsible for identifying a Medicaid or NJ FamilyCare-Plan A beneficiary inpatient or a Medicaid or NJ FamilyCare-Plan A applicant inpatient who may be at risk of NF placement.

1. The identification process shall also include any inpatient in need of NF care who may become a Medicaid or NJ FamilyCare-Plan A beneficiary within six months after NF admission, as well as individuals meeting PASRR Level I criteria. (See *N.J.A.C. 10:52-1.9(c)*.) These patients shall be referred by the hospital to the OCCO and the CWA on the basis of the "At Risk Criteria for Nursing

Facility Placement and Referral to the OCCO for PAS Evaluation" in (g) below. Medicaid or NJ FamilyCare-Plan A beneficiaries already residing in Medicaid participating facilities who are transferred to an acute care hospital and who are transferred to either the same or a different NF, shall not require PAS authorization.

i. Within one working day of identifying an inpatient as being at risk for NF placement, the hospital discharge planner or social worker shall:

(1) Make a telephone or FAX referral to the OCCO and the CWA;

(2) If not already a Medicaid or NJ FamilyCare-Plan A beneficiary, generate a Public Assistance Inquiry (PA-1C) to initiate the application process for Medicaid or NJ FamilyCare-Plan A; and

(3) Within two working days of the telephone referral to the OCCO and CWA, the Hospital Discharge Planning Office shall forward the completed "Hospital Preadmission Screening Referral (LTC-4)" to the OCCO, unless the LTC-4 was faxed on the day of the referral.

2. The Level II PASRR evaluation for individuals identified as meeting the PASRR criteria shall be completed by a Board eligible or Board certified psychiatrist or APN certified in psychiatric/mental health:

i. The hospital discharge planning unit or social services department shall immediately arrange through the individual's attending physician, a consultation by a Board eligible, a Board certified hospital staff psychiatrist or an APN certified in mental health to complete the "PASRR Psychiatric Evaluation" (DMHS 2009) form. The "PASRR Psychiatric Evaluation" form shall not be completed until such time as the professional staff designated by DHSS has determined the level of care and the need for a PASRR Level II evaluation.

ii. Within 48 hours of completion of the PASRR Level II evaluation, the completed "PASRR Psychiatric Evaluation" form shall be faxed to (609) 777-0662 or mailed to the Division of Mental Health Services, PO Box 727, Trenton, New Jersey 08625-0727, Attention: PASRR Coordinator.

(1) A copy of the "PASRR Psychiatric Evaluation" form may be requested from the PASRR Coordinator in the Division of Mental Health Services.

iii. The OCCO shall contact the appropriate Regional Office of the Division of Developmental Disabilities (DDD) agency to advise them of the need for a Level II PASRR evaluation. The Level II PASRR evaluation will be completed by the DDD staff within three working days of the OCCO contact.

iv. DMHS or DDD shall notify the OCCO of the determination of need for specialized services who, in turn, shall provide the hospital discharge planning unit or social services department with the approval or denial decision for placement in a Medicaid-certified NF.

(g) The following "At-Risk Criteria for Nursing Facility Placement and Referral to the OCCO for PAS" shall be utilized by the hospital in determining if a referral for long-term care services, either in an NF or in the community, is indicated:

1. The medical criteria are as follows. Has the patient experienced any of the following:

i. Catastrophic illness requiring major changes in lifestyle or living conditions, such as, multiple sclerosis, stroke, multiple trauma, AIDS, amputation, neurological disease, cancer, birth defect(s), or end stage renal disease;

ii. Debilitation or chronic illness causing progressive deterioration of self-care skills, such as, severe chronic disease, spina bifida, progressive pulmonary disease or diabetes;

iii. Multiple hospital admissions within the past six months not including patients admitted directly from NFs;

iv. Previous NF admissions within the past two years; or

v. Major health needs, that is, tube feedings, special equipment or treatments, rehabilitation/restorative services.

2. The social criteria are as follows: In addition to the medical criteria, does the patient meet any of the following social situations:

i. Homeless;

ii. Lives alone and/or has no immediate support system;

iii. Primary caregiver is not able to provide required care services; or

iv. Lack of adequate support systems.

3. The financial criteria are as follows. Does the patient meet any of the income and asset tests:

i. Currently eligible for Medicaid or NJ FamilyCare-Plan A;

ii. Monthly income at/or below the current institutional level specified at *N.J.A.C. 10:71-5.6*.

(1) Has no spouse in the community and resources no greater than those specified at *N.J.A.C. 10:71-4.4* and *4.5*;

(2) Has no spouse in the community and has resources at or below the maximum amount allowable, as determined by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Medicare Catastrophic Coverage Act of 1988 (see *N.J.A.C. 10:71*). (This is an indication that the patient may become Medicaid or NJ FamilyCare-Plan A eligible within the next six months by spending down assets in an NF as private pay); or

(3) Has a spouse in the community with combined countable resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see *N.J.A.C. 10:71*).

iii. Monthly income at or below the current New Jersey Care . . . Special Medicaid programs maximum monthly income limit specified at *N.J.A.C. 10:72-4.1* and:

(1) Has no spouse in the community and resources no greater than those specified at *N.J.A.C. 10:71-4.4* and *4.5*;

(2) Has no spouse in the community and resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see *N.J.A.C. 10:71*). This is an indication that the patient may become Medicaid or NJ FamilyCare-Plan A eligible within the next six months by spending down assets in an NF as private pay; or

(3) Has a spouse in the community with combined countable resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see *N.J.A.C. 10:71*).

(h) The hospital discharge planner or social worker shall be responsible for the discharge or placement arrangements of the patient.

1. For each hospital patient referred for PAS, the hospital shall complete and send to the OCCO a "Hospital Preadmission Screening Discharge form (LTC-8)."

i. For any patient discharged to a NF, a Discharge Package (HSDP, discharge paper work, DHSS approval letter, hospital transfer sheet and PASRR documentation, including any documentation which supports a diagnosis of Alzheimer's disease or related organic dementia) shall be compiled to accompany the patient to the NF.

(1) If the patient being transferred to a NF is eligible for Medicare benefits, the transfer shall be made to a Medicare/Medicaid participating NF.

ii. For those beneficiaries discharged to community locations, the hospital social worker or discharge planner shall be responsible for the implementation of the HSDP by securing home care services.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.9* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.10*, Recordkeeping, recodified to *N.J.A.C. 10:52-1.11*.

Recodified from *N.J.A.C. 10:52-1.10* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote the section. Former *N.J.A.C. 10:52-1.11*, Recordkeeping, recodified to *N.J.A.C. 10:52-1.12*.

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

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

Rewrote the section.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Rewrote (b) through (f).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-1.12

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.12 Recordkeeping

Hospitals shall be required to keep 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. This information shall be available upon the request of the Division or its agents.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.10* by R.1998 d.564, effective December 7, 1998.

See: *30 New Jersey Register 1257(a)*, *30 New Jersey Register 4225(a)*.

Former *N.J.A.C. 10:52-1.11*, Second opinion program for elective surgical procedures, recodified to *N.J.A.C. 10:52-1.12*.

Recodified from *N.J.A.C. 10:52-1.11* by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Former *N.J.A.C. 10:52-1.12*, Second opinion program for elective surgical procedures, recodified to *N.J.A.C. 10:52-1.13*.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-1.13

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

§ 10:52-1.13 Second opinion program for elective surgical procedures

(a) A second opinion shall be obtained for any elective surgical procedures listed under (b) below. The outcome of the second opinion shall have no bearing on reimbursement. Once the second opinion is rendered, the beneficiary shall retain the right to decide whether or not to proceed with the surgery; however, failure to obtain a second opinion for these procedures shall result in a denial of the hospital claim.

1. If the operating physician determines that the need for surgery is urgent or is an emergency, no second opinion shall be required. "Urgent" or "emergency" includes any situation in which a delay in performing surgery in order to meet the second opinion requirement could result in a significant threat to the patient's health or life.

i. Reimbursement for urgent or emergency surgery shall be made only if a specific statement is attached to the claim form by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. If the Medicaid/NJ FamilyCare beneficiary is covered by another health insurance carrier (except Medicare), which makes only partial payment on the claim, the fiscal agent shall not make supplementary payment unless the second opinion requirement has been met. However, the fiscal agent shall make payment on the claim if the hospital receives documentation that a second opinion was arranged for and paid for by another health insurance carrier. A copy of this documentation shall be attached to the claim form.

(b) The following elective surgical procedures fall under the Second Opinion Program:

1. Hernia Repair (common abdominal wall type);

i. A second opinion shall be required for any herniorrhaphy involving an adult over 18 years of age.

ii. A second opinion shall not be required for herniorrhaphy involving a child or young adult 18 years of age or under.

2. Hysterectomy (See also *N.J.A.C. 10:52-2.14*);

3. Laminectomy;

4. Spinal fusion;

i. A second opinion shall not be required for spinal fusion for scoliosis in a child or young adult 18 years of age or under.

(c) A second opinion shall be arranged through the Medicaid Second Opinion Referral Services of the Provider Services Unit at the fiscal agent.

1. A consultation ordered by a physician shall not meet the Program's definition of a second opinion and no "Authorization for Payment" shall be granted based on such a consultation. The only exception to this policy involves second opinions arranged and paid for by other health insurance carriers. (See (a)2 above.)

2. In order to prevent claim denial as a result of a situation in which one of the elective surgical procedures is scheduled and performed before the second opinion requirement is met, it is suggested that the elective surgery not be scheduled until after the second opinion has been rendered.

(d) Neither the physician claim nor hospital claim associated with one of the second opinion procedures shall be paid unless attached to the hard copy is an "Authorization for Payment," or documentation of a second opinion arranged through another health insurance carrier, or a specific statement from the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

1. Reimbursement shall not be made for a second opinion rendered to an individual who is not a Medicaid/NJ FamilyCare fee-for-service beneficiary. The issuance of a Second Opinion Referral to the beneficiary by the Program's Second Opinion Referral Services of the Provider Services Unit shall not guarantee the individual's eligibility on the date of the second opinion or subsequent surgery. The individual's current Medicaid/NJ FamilyCare eligibility shall be verified by checking the individual's current New Jersey HBID card before rendering any service. (See *N.J.A.C. 10:49-2.2* and *2.5*, Administration--How to Identify a Medicaid/NJ FamilyCare Beneficiary).

(e) For physician requirements regarding Second Opinion procedures, see *N.J.A.C. 10:54*, Physician Services.

History

HISTORY:

Amended by R.1998 d.352, effective July 20, 1998.

See: *30 N.J.R. 1258(a)*, *30 N.J.R. 2653(a)*.

In (a), substituted "beneficiary" for "recipient" in the introductory paragraph and inserted a reference to NJ KidCare in 2; in (b), rewrote 1, changed the N.J.A.C. reference in 2, and deleted 5; and in (d)1, substituted "beneficiary" for "recipient", deleted references to Medicaid, and inserted references to NJ KidCare throughout.

Recodified from *N.J.A.C. 10:52-1.11* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.12*, Social Necessity Days, recodified to *N.J.A.C. 10:52-1.13*.

Recodified from *N.J.A.C. 10:52-1.12* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to reimbursement for a reference to payment in the introductory paragraph, and substituted a reference to NJ KidCare Plan--A, B or C beneficiaries for a reference to NJ KidCare beneficiaries; in (b)2 and (d)1, changed N.J.A.C. references; and in (d)1, substituted a reference to NJ KidCare fee-for-service beneficiaries for a reference to NJ KidCare beneficiaries. Former *N.J.A.C. 10:52-1.13*, Social Necessity Days, recodified to *N.J.A.C. 10:52-1.14*.

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

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

In (a)2, and (d)1, substituted references to FamilyCare for references to KidCare.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a)2 and (d)1, substituted "Medicaid/NJ" for "Medicaid or NJ" throughout; in (a)2, inserted a comma following "Medicare)"; and in (d)1, substituted "HBID card" for "Validation Form".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-1.14

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.14 Social Necessity Days

(a) Payment for "Social Necessity Days" shall be made to hospitals for a maximum of 12 calendar days per hospitalization for a Medicaid/NJ FamilyCare-Children's Program fee-for-service beneficiary child admitted with the diagnosis of child abuse or suspected child abuse, if special circumstances (social necessity) prevent the discharge or transfer of the patient and the hospital has taken effective action to initiate discharge or transfer of the patient.

1. For these cases, it is not necessary for the day of admission to be at the acute level of care.

2. Effective action is defined as telephone notification to the county welfare agency (CWA), or Division of Child Protection and Permanency (CP&P) local office, or other responsible officials as may be designated, within 48 hours of the time that the stay is determined to be no longer medically necessary. This telephone contact then shall be confirmed in writing within three working days. A copy of the written notification shall be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).

3. Medicaid/NJ FamilyCare-Children's Program reimbursement for social necessity shall be made to hospitals paid in accordance with the DRG rate setting methodology in N.J.A.C. 10:52-5 through 7 and 9 prior to August 3, 2009, and in accordance with N.J.A.C. 10:52-14 on or after August 3, 2009.

i. Payment for Social Necessity Days will be made at the Statewide average per diem rate paid to Medicaid participating nursing facilities (NF) as determined on January 1 of each calendar year.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.12* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.13*, Utilization control (inpatient services), recodified to *N.J.A.C. 10:52-1.14*.

Recodified from *N.J.A.C. 10:52-1.13* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to Medicaid and NJ KidCare--Plan A fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph, substituted a reference to CBOSS for a reference to CWA in 2, and substituted a reference to Medicaid and NJ KidCare--Plan A reimbursement for a reference to Medicaid reimbursement in 3. Former *N.J.A.C. 10:52-1.14*, Utilization control (inpatient services), recodified to *N.J.A.C. 10:52-1.15*.

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

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

In (a), substituted "FamilyCare-Children's Program" for "KidCare Plan A" in the introductory paragraph and 5.

Amended by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

In (a)3, inserted "7 and" and "prior to August 3, 2009 and in accordance with N.J.A.C. 10:52-14 on or after August 3, 2009".

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Added (a)3i.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a), and in (a)3, substituted "Medicaid/NJ" for "Medicaid or NJ"; and rewrote (a)2.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-1.15

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.15 Utilization control (inpatient services)

(a) This section provides information on the requirements for utilization control for inpatient services for approved acute general hospitals, special hospitals, and private psychiatric hospitals, with the exception of inpatient psychiatric hospital services for individuals under the age of 21. See *N.J.A.C. 10:52-1.16*.

(b) For purposes of this rule, the following words and terms shall have the following meanings:

"Utilization control" means an approved program instituted, implemented and operated by or under the authorization of a utilization review organization (URO) which effectively safeguards against unnecessary or inappropriate Medicaid/NJ FamilyCare services and assesses the quality of those services to Medicaid/NJ FamilyCare fee-for-service beneficiaries.

(c) Under the Social Security Act, Section 1903(g) and (h), the Division is responsible for an effective program to control the utilization of services in hospitals. (See 42 CFR Part 456, Utilization Control, Subchapter B, C, and D). The required reviews of inpatient hospital services shall be conducted by Quality Improvement Organizations (QIOs), which shall be reimbursed by the State once a contract has been secured to provide these services in accordance with *N.J.A.C. 10:52-14.6(a)*2i. Included under utilization control are: Certification and recertification of the need for inpatient care; medical, psychiatric and social evaluations; a plan of care established and periodically reviewed and evaluated by a physician; and a continuous program of utilization review under which the admission of each beneficiary is reviewed or screened. Hospital entitlement to Medicaid/NJ FamilyCare reimbursement for services rendered to a Medicaid/NJ FamilyCare fee-for-service beneficiary for each period of hospitalization shall be subject to the following requirements:

1. A physician shall certify, for each beneficiary or applicant, that inpatient services in the acute care or in the private psychiatric hospital are or were needed.

i. The certification shall be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid/NJ FamilyCare program authorizes payment.

ii. The certification shall be in writing and signed, or initialed, by a physician. The signature or initials are not acceptable if they are rubber stamped unless the physician has initialed the stamped signature. The physician shall date the certification on the date he or she signs it.

iii. The certification for any Medicaid/NJ FamilyCare fee-for-service patient shall be maintained in the beneficiary's medical record.

iv. Acceptable documentation for certification or recertification may be any of the following:

(1) A statement signed and dated, by the attending physician, staff physician, and/or consultant physician who has knowledge of the case, attesting that the beneficiary is in need of hospital care.

(2) Physician's orders which are signed and dated on admission and clearly attest to the need for hospital care.

(3) A medical evaluation which designates the services and which is signed and dated by a physician who has knowledge of the case.

(4) An admission review form signed and dated by an attending or staff physician who has knowledge of the case.

2. A physician shall recertify, for each Medicaid/NJ FamilyCare fee-for-service beneficiary or applicant, that inpatient services in a hospital are needed.

i. Recertification shall be made at least every 60 days after certification.

ii. The recertification shall be in writing, shall attest to the need for inpatient services, and shall be signed or initialed by a physician who has knowledge of the case.

iii. The physician shall date the recertification on the date that he or she signs it.

iv. The recertification shall demonstrate the need for the level and type of care that the beneficiary is receiving.

v. The recertification for any Medicaid/NJ FamilyCare fee-for-service beneficiary shall be maintained in the beneficiary's medical record.

vi. Acceptable documentation for recertification shall include any one of the following:

(1) A signed and dated statement by the physician who has knowledge of the case, attesting that continued care of a particular level or type is needed; or,

(2) Signed and dated orders by the physician who has knowledge of the case that clearly indicated that continued care is needed; or,

(3) Signed and dated progress notes by the physician who has knowledge of the case that clearly indicate that continued care is needed; or,

(4) Signed and dated reports that a physician might use in caring for the beneficiary that clearly indicate that continued care is needed; or,

(5) An admission certification or recertification form signed and dated by a physician who has knowledge of the case; or

(6) Utilization Review Committee (URC) minutes or form which indicate that the beneficiary's care was reviewed by a physician who had knowledge of the case and that continued care was needed. The physician's signature, with the date, shall be attached to the URC minutes or forms.

3. Any days billed by the hospital that are not in compliance with the certification/recertification requirements in (b)1 and 2 above shall be considered non-certified days and shall not be reimbursed by the Division.

i. Claims submitted that include non-certified days, (that is, "carved out" days or continued stay denials) as determined by the Division or its agents to affect billing, shall be billed "hard copy" and be accompanied by a certification of stay form.

(d) Before admission of an applicant or beneficiary to a private psychiatric hospital or before authorization for payment, the attending or staff physician shall make a medical evaluation of each applicant's or beneficiary's need for care in the hospital; and appropriate personnel shall make a psychiatric and social evaluation.

1. Each medical evaluation shall include the following:

i. Diagnoses;

ii. Summary of present medical findings;

iii. Medical history;

iv. Mental and physical functional capacity;

v. Prognoses; and,

vi. A recommendation by a physician concerning admission to the mental hospital, or continued care in the hospital for individuals who apply for Medicaid or NJ FamilyCare while in the private psychiatric hospital.

(e) A plan of care shall be established prior to admission. Before admission of an applicant or beneficiary to an acute care general, special hospital, or private psychiatric hospital or before authorization for payment, a physician and other personnel in an acute care general and special hospital or the attending or staff physician in a private psychiatric hospital involved in the care of the individual shall establish a written plan of care for each Medicaid/NJ FamilyCare beneficiary or applicant.

1. The plan of care shall include:

i. Diagnoses, symptoms, complaints, and complications, indicating the need for admission;

ii. A description of the functional level of the individual;

iii. Objectives of the care (in private psychiatric hospitals only);

iv. Any order for diagnostic procedures; medications; treatments; consultations; restorative and rehabilitative services; patient activities; therapies; social services; diet; and, for private psychiatric hospitals only, special procedures for the health and safety of the patient;

v. Plans for continuing care, as appropriate; and, in a private psychiatric hospital, the review and modification of the plan of care; and,

vi. Plans for discharge, as appropriate.

2. Orders and activities shall be developed in accordance with the physician's instructions, (only for acute care general and/or special hospitals).

3. Orders and activities shall be reviewed and revised as appropriate by all personnel involved in the care of an individual (only for acute care general and/or special hospitals).

4. In acute care general and special hospitals, a physician and other personnel involved in the Medicaid/NJ FamilyCare beneficiary's case shall review each plan of care at least every 60 days.

5. In private psychiatric hospitals, for beneficiaries age 65 or over, the attending or staff physician and other personnel involved in the beneficiary's care shall review each plan of care at least every 90 days; and

6. Reports of evaluations and plans of care shall be entered in the applicant's or beneficiary's record, as follows:

i. At the time of admission; or

ii. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

(f) For the Utilization Review (UR) Plan, each hospital shall evaluate the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. The UR includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices. (See *42 CFR 456.100* through *456.145*, incorporated herein by reference.)

1. Upon admission of the patient to the hospital, a discharge plan shall be initiated and thereafter reviewed and updated regularly.

2. Any Medicaid/NJ FamilyCare-Plan A beneficiary or potential Medicaid/NJ FamilyCare-Plan A beneficiary who is considered for admission to a NF shall receive a preadmission screening in accordance with *N.J.A.C. 10:52-1.11*.

3. When an inpatient is to be discharged from the hospital and continuing medical care is required, either in another medical facility (such as a NF, special hospital) or by a community health agency (such as a home health agency), the hospital shall provide the facility or agency with a legible abstract or summary of the patient's care while hospitalized and recommendations for further medical care.

i. This information shall be provided at the time of hospital discharge and shall be signed by the attending physician. The patient information transfer form (adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association) for a transfer from a hospital to a NF, or an equivalent transfer form, shall be used.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.13* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.14*, Utilization control; inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals, recodified to *N.J.A.C. 10:52-1.15*.

Recodified from *N.J.A.C. 10:52-1.14* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare fee-for-service throughout; in (b), deleted "Utilization Review Organization (URO)" definition; in (c), substituted a reference to Medicaid and NJ KidCare--Plan reimbursement for a reference to Medicaid payment in the introductory paragraph; in (d)1vi, inserted a reference to NJ KidCare; in (e), inserted references to NJ KidCare beneficiaries throughout; and in (f)2, inserted references to NJ KidCare--Plan A beneficiaries, and changed N.J.A.C. reference. Former *N.J.A.C. 10:52-1.15*, Utilization control; inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals, recodified to *N.J.A.C. 10:52-1.16*.

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

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

Rewrote the section.

Amended by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

In the introductory paragraph of (c), deleted a comma preceding "and D)", and substituted "Quality Improvement Organizations (QIOs)" for "Utilization Review Organizations (UROs)" and "State once a contract has been secured to provide these services in accordance with *N.J.A.C. 10:52-14.6(a)*2i." for "hospitals. Reimbursement rates shall include funding for these required reviews.".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout; in the introductory paragraph of (c), inserted a comma following "C"; and in the introductory paragraph of (f), inserted a comma following "stay".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-1.16

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.16 Utilization control: inpatient psychiatric services for beneficiaries under 21 years of age in private psychiatric hospitals

(a) This section specifies the unique requirements for certification of the need for inpatient psychiatric services provided to beneficiaries under 21 years of age in private psychiatric hospitals. In accordance with Section 1905(a)16 and (h) of the Social Security Act, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the beneficiary's condition. This section also includes general requirements; certification of the need for services, which involves "active treatment" as defined in (c) below; requirements for the team certifying the need for services; and requirement for an individual plan of care. These requirements do not apply to an admission to a psychiatric unit of a general hospital. See *N.J.A.C. 10:52-1.15* for requirements on utilization control in an acute care general hospital.

(b) This rule applies only to inpatient psychiatric services in an approved private psychiatric hospital for the treatment of children and youths before NJ FamilyCare-Children's Program beneficiaries reach age 19 and before the Medicaid beneficiary reaches age 21 or, if the Medicaid beneficiary was receiving the services immediately before he reached age 21, before the earlier of the following:

1. The date the beneficiary no longer requires the services; or

2. The date the beneficiary reaches age 22. (See *42 CFR 441.151*).

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

1. "Active treatment" means implementation of a professionally developed and supervised plan of care, as described in (f) below, that is:

i. Developed and implemented no later than 14 days after admission; and,

ii. Designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time.

2. "Independent team" means a team that is not associated with the facility; for example, none of the members of the team has an employment or consultant relationship with the admitting facility. The independent team shall include a physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry and who has knowledge of the individual's clinical condition and situation.

3. "Interdisciplinary team," as described in Federal regulations in *42 CFR 441.156*, is comprised of those employed by, or those who provide services to, Medicaid/NJ FamilyCare beneficiaries in the facility or program, and include, at a minimum, either a Board-eligible or Board-certified psychiatrist; or a physician and a clinical psychologist who has a doctoral degree; or a physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a Master's degree in clinical psychology or who has been certified by the State psychological association; and one of the following:

i. A psychiatric social worker;

ii. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;

iii. A psychologist who has a Master's degree in clinical psychology or who has been certified by the State or by the State psychological association; or,

iv. An occupational therapist who is licensed by the State in which the individual is practicing, if applicable, and who has specialized training or one year experience in treating mentally ill individuals.

4. "Plan of care" means a written plan developed for each beneficiary to improve the beneficiary's condition to the extent that the beneficiary no longer needs inpatient care.

(d) Certification of the need for services (see *42 CFR 441.152*) shall be made by a team, either independent or interdisciplinary, as specified in (e) below, and shall include the following statements: The team shall certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;

2. Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

3. Services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that inpatient services would no longer be needed.

(e) The certification of the need for services, as stated in (d) above, shall be made by teams, in accordance with Federal regulations, *42 CFR 441.153* and specified as follows:

1. Certification for the admission of an individual who is a beneficiary when admitted to a facility or program shall be made by an independent team, as described in (c) above.

2. Certification for an inpatient applying for Medicaid/NJ FamilyCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (c) above.

3. Certification of an emergency admission of a beneficiary shall be made by the interdisciplinary team responsible for the plan of care, in accordance with Federal regulation, *42 CFR 441.156*, and as described in (f)1 below.

(f) Within 14 days of admission to a private psychiatric hospital, or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or beneficiary to improve the beneficiary's condition to the extent that inpatient care no longer is necessary, in accordance with (e) above. (See *42 CFR 456.180* and *456.181*.)

1. The plan of care shall:

i. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary's clinical condition and situation and reflects the beneficiary's need for inpatient psychiatric care;

ii. Be developed by a team of professionals as described in (g) below in consultation with the beneficiary, the beneficiary's parents, legal guardians or others in whose care he or she will be released after discharge;

iii. State treatment objectives;

iv. Prescribe an integrated program of therapies, activities and experiences designed to meet the beneficiary's treatment objectives; and

v. Include, at an appropriate time, post discharge plans and coordination of inpatient services with the partial discharge plan and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.

2. The plan shall be reviewed every 30 days by the team to:

i. Determine that services being provided are or were required on an inpatient basis; and,

ii. Recommend changes in the plan as indicated by the beneficiary's overall adjustments as an inpatient.

(g) Functions of the interdisciplinary team developing the individual plan of care are as follows:

1. The individual plan of care as described under *42 CFR 441.155*, shall be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the psychiatric hospital.

2. Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of the following:

i. Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities;

ii. Assessing the potential resources of the beneficiary's family;

iii. Setting treatment objectives; and,

iv. Prescribing therapeutic modalities to achieve the plan's objectives.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.14* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Former *N.J.A.C. 10:52-1.15*, Utilization control; outpatient psychiatric services, recodified to *N.J.A.C. 10:52-1.16*.

Recodified from *N.J.A.C. 10:52-1.15* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted references to beneficiaries for references to recipients throughout; in (b), inserted "before the NJ KidCare beneficiaries reach age 19 and" in the introductory paragraph; and in (c)3 and (e)2, inserted references to NJ KidCare. Former *N.J.A.C. 10:52-1.16*, Utilization control; outpatient psychiatric services, recodified to *N.J.A.C. 10:52-1.17*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (c)3, substituted "Medicaid/NJ" for "Medicaid and NJ"; and in (e)2, substituted "Medicaid/NJ" for "Medicaid or NJ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-1.17

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.17 Utilization control; outpatient psychiatric services

(a) The following requirements in this rule were developed to help ensure the appropriate utilization of outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a plan of care, performance of periodic reviews for evaluation purposes, and supportive documentation for services rendered. Outpatient psychiatric services include the initial evaluation; individual psychotherapy; group psychotherapy; family therapy; family conference; partial hospitalization (see *N.J.A.C. 10:52-2.10*); psychological testing; and medication management.

(b) The intake evaluation shall be performed as follows:

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

i. Evaluates the beneficiary's mental condition; and

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

iii. Includes certification (signed statement) by the evaluation team that the program is appropriate to meet the patient's treatment needs; and,

iv. Is made part of the patient's records.

(c) The evaluation team requirements shall be as follows:

1. The evaluation team for the intake process shall include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified, in accordance with *42 CFR 441.153*).

(d) The plan of care requirements shall be as follows:

1. A written individualized plan of care shall be developed by the evaluation team for each patient who receives continued treatment. The plan of care shall be included in the patient's records and shall be designed to improve the patient's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The plan of care shall consist of the following:

i. A written description of the treatment objectives which include the treatment regimen, the specific medical and remedial services, therapies, and activities that will be used to meet the objectives;

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

iii. A description designation of the type of personnel that will be furnishing the services; and,

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

(e) Documentation for outpatient psychiatric services shall be as follows:

1. For psychiatric services, the outpatient department shall develop and maintain written documentation to support each medical or remedial therapy, service, activity or session for which billing is made. Such documentation shall include, at a minimum, the following:

i. The specific services rendered, such as individual psychotherapy or family therapy;

ii. The date and the actual time services were rendered;

iii. The duration of services provided, such as 1 hour or 1/2 hour;

iv. The signature of the practitioner who rendered the services;

v. The setting in which services were rendered; and,

vi. A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

2. Clinical progress, complications and treatment which affect prognosis or progress shall be documented in the patient's medical record at least once a week for partial hospitalization and at each patient contact or visit for other psychiatric services. Any other information important to the clinical picture, therapy and prognosis shall also be documented.

i. The individual services provided under partial hospitalization shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, shall be made at least once a week.

3. For services requiring prior authorization, such as partial hospitalization (see *N.J.A.C. 10:52-2.11*), a departure from the plan of care requires a new request for prior authorization when a change in the patient's clinical condition necessitates an increase in the frequency and intensity of services or change in the type of services which will exceed the services authorized.

(f) Periodic reviews shall be conducted as follows:

1. The evaluation team shall periodically review the patient's plan of care on a regular basis (at least every 90 days) to determine:

i. The patient's progress toward the treatment objectives;

ii. The appropriateness of the services being furnished; and

iii. The need for the patient's continued participation in the program.

2. The periodic reviews should be documented in detail in the patient's records and made available upon request of the Division or its agents.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-1.15* by R.1998 d.564, effective December 7, 1998.

See: *30 N.J.R. 1257(a)*, *30 N.J.R. 4225(a)*.

Recodified from *N.J.A.C. 10:52-1.16* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a) and (e), changed N.J.A.C. references; and in (b), substituted references to beneficiaries for references to recipients throughout.

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

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

Rewrote the section.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (c)1, substituted "CFR 441.153" for "CFR 153".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-1.18

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:52-1.18 Advance directives

All hospitals participating in the New Jersey Medicaid/NJ FamilyCare program are subject to the provisions of State and Federal statutes regarding advance directives including, but not limited to, appropriate notification to patients of their rights, development of policies and practices and communication to, and education of, staff, community and interested parties. See *N.J.A.C. 10:49-9.15*, and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (*42 U.S.C. §§ 1396a(a)(58)* and *1396a(w)*) for detailed information.

History

HISTORY:

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

See: *32 New Jersey Register 2687(b)*, *33 New Jersey Register 2808(a)*.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Substituted "FamilyCare" for "KidCare" in the first sentence and rewrote the last sentence.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.1

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.1 Ambulatory Surgical Center (ASC)

(a) An Ambulatory Surgical Center (ASC) shall be any distinct entity that operates for the purpose of providing surgical services to patients not requiring hospitalization which has an agreement with the Centers for Medicare & Medicaid Services (CMS) to participate in the Medicare program and meets the specific conditions for coverage set forth in Federal regulations in 42 CFR Part 416.

(b) An ASC, as described in N.J.A.C. 10:66-5, may be operated by a hospital that is under common ownership or control of a hospital.

1. An ASC operated by a hospital shall be a separately identifiable entity physically and administratively and shall be financially independent and distinct from other operations of the hospital.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (b)1, changed N.J.A.C. reference in the introductory paragraph.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.2

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.2 Blood and blood products

(a) Reimbursement may be made for blood provided to an inpatient or an outpatient of an approved hospital when prescribed and supervised by a licensed physician.

(b) Whole blood and derivatives, and necessary processing and administration thereof, may be reimbursed with the following limitations:

1. Efforts should be made by the family or the provider to arrange for the replacement of blood. This can be done by the contribution of a blood donor or by using a blood replacement plan in which the Medicaid/NJ FamilyCare fee-for-service eligible beneficiary is a beneficiary of the blood replacement plan (if available).

2. The cost of donated blood or blood products (including autologous donation) received through a replacement plan shall not be reimbursable. However, the charge for phlebotomy, cross-matching, indexing, storage and transfusing shall be reimbursable.

3. In order to obtain Medicaid/NJ FamilyCare reimbursement, the hospital shall submit a certification that a voluntary blood donation cannot be obtained.

i. When arrangements for payment for the replacement of blood are not accomplished, reimbursement to the hospital shall be 100 per cent of the "add-on" charge.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (b)1, substituted "Medicaid/NJ" for "Medicaid or NJ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-2.3

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

§ 10:52-2.3 Dental services

(a) Dental services in the outpatient department shall be provided in accordance with the requirements contained in *N.J.A.C. 10:56*, Dental Services. The outpatient dental department shall be subject to the same policies and procedures that apply to the Medicaid/NJ FamilyCare fee-for-service provider of dental services in the community, with the following exceptions:

1. Emergency dental care provided under special circumstances in a hospital emergency room; or

2. Outpatient dental services provided to NJ Medicaid/NJ FamilyCare fee-for-service beneficiaries with chronic medical conditions and/or developmental disabilities resulting in special healthcare needs.

(b) A hospital with an outpatient dental department serving Medicaid/NJ FamilyCare fee-for-service beneficiaries is given a unique provider number for that department. A hospital that starts an outpatient dental department shall request a provider number for that department from the fiscal agent.

(c) Reimbursement for a dental service is determined by the Commissioner of the Department of Human Services in accordance with *N.J.A.C. 10:56*, and is based on the same fee, conditions, and definitions for the corresponding service, utilized for the payment of individual Medicaid/NJ FamilyCare fee-for-service dental practitioners and providers in the community, except in cases in which the beneficiary's special healthcare needs, as described in (a)1 or 2 above, require that dental services be performed in the outpatient operating room setting. Reimbursement for outpatient operating room charges for services provided to clients with special healthcare needs, as described in (a)1 or 2 above, shall be at the hospital's outpatient cost-to-charge ratio. In no event shall the charge to the Division exceed the charge by the provider for identical services to other groups or individuals in the community.

1. If a dental procedure code is assigned both a specialist and non-specialist "Maximum Fee Allowance Schedule", the amount of the payment will be based upon the status (specialist or non-specialist) of the individual practitioner who actually provided the billed service.

i. If the dentist providing the services is a resident, intern, or house staff member, the status of the supervising dentist, specialist or non-specialist, determines the amount of the payment.

2. Covered emergency dental care performed in the hospital emergency room shall not be reimbursed if the services were provided in the emergency room and the dental clinic was available at the same time.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), inserted a reference to NJ KidCare fee-for-service providers in the introductory paragraph, and substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients in 1; and in (b), inserted a reference to NJ KidCare fee-for-service dental practitioners in the introductory paragraph.

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

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

In (a), substituted "be provided in accordance with the requirements contained in" for "follow the policies and procedures outlined in" in the introductory paragraph; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2012 d.028, effective February 6, 2012.

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

Rewrote (a); recodified former (a)1 as new (b) and former (b) as (c); and rewrote the introductory paragraph of (c).

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a) and of (c), and in (b), substituted "Medicaid/NJ" for "Medicaid or NJ"; and in the introductory paragraph of (c), inserted a comma following "conditions".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.4

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federally-mandated comprehensive and preventive child health program for Medicaid/NJ FamilyCare-Children's Program fee-for-service beneficiaries from birth through 20 years of age (see 42 CFR 441 Subpart B). The goal of the program is to assess the beneficiary's health needs through initial and periodic examinations (screenings); to provide health education and guidance; and to assure that health problems are prevented, diagnosed, and treated at the earliest possible time.

1. As a condition of participation in Medicaid/NJ FamilyCare, all ambulatory care facilities (including hospital outpatient departments) providing primary care to children and adolescents from birth through 20 years of age, shall participate in the EPSDT program and shall provide, at a minimum, the required EPSDT screening services.

(b) The required EPSDT services shall include the following:

1. Screening services, the components of which are described below:

i. A comprehensive health and developmental history, including an assessment of both physical and mental health development;

ii. A culturally-sensitive and valid developmental assessment. The parameters used in assessing the child's developmental level and behavior shall be appropriate for the child's age. While no specific test instrument is endorsed, it is expected that an evaluation of a young child would, at a minimum, address the child's gross and fine motor coordination, language/vocabulary and adaptive behavior, including self-help and self-care skills and social emotional development. An assessment of a school-age child should include school performance, peer relationships, social activity and behavior, physical and athletic aptitude and sexual maturation;

iii. A comprehensive unclothed physical examination, including vision and hearing screening, dental inspection and nutritional assessment;

iv. Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines, incorporated herein by reference, as amended and supplemented. The schedule can be found on the Centers for Disease Control (CDC) website at *https://www.cdc.gov/* or can be requested from the Centers for Disease Control and Prevention, National Immunization Program, Division of Epidemiology and Surveillance, Mail Stop E61, 1600 Clifton Road, NE Atlanta, Georgia 30333;

v. Age-appropriate laboratory and other diagnostic tests, including:

(1) Hemoglobin or hematocrit;

(2) Lead screening, using blood lead level determinations, once between nine and 18 months (preferably at 12 months), once between 18 and 26 months (preferably at 24 months) and, for any child who has not been previously tested between 27 months and 72 months;

(3) Urinalysis;

(4) Tuberculin skin test (Mantoux), intradermal, administered annually and when medically indicated; and

(5) Additional laboratory tests which may be appropriate and medically indicated shall be obtained, as necessary;

vi. Health education, including anticipatory guidance;

vii. Referral for further diagnosis and treatment or follow-up of all correctable abnormalities, uncovered or suspected. Referral may be made to the provider conducting the screening examination or to another provider, as appropriate; and

viii. Referral to the Special Supplemental Food Program for Women, Infants and Children (WIC) for children under five years of age and for pregnant or lactating women.

2. Vision services as follows:

i. Vision screening, which shall include the following:

(1) If a newborn, the examination shall include general inspection of the eyes, visualization of the red reflex and evaluation of ocular motility;

(2) An appropriate medical and family history;

(3) An evaluation, by age six months, of eye fixation preference, muscle imbalance and papillary light reflex; and

(4) A third examination with visual acuity testing by age three or four years;

ii. Vision testing for school-aged children, which shall be performed at the following grades and ages:

(1) Kindergarten or first grade (five or six years);

(2) Second grade (seven years);

(3) Fifth grade (10 or 11 years);

(4) Eighth grade (13 or 14 years); and

(5) Tenth or eleventh grades (15 or 17 years).

iii. Referral for vision testing if a child:

(1) Cannot read the majority of the 20/40 line before his or her fifth birthday;

(2) Has a two-line difference of visual acuity between the eyes;

(3) Has suspected strabismus; or

(4) Has an abnormal light or red reflex.

3. Dental services as follows:

i. Dental screening, which shall include the following:

(1) An intraoral examination, including observation of tooth eruption, occlusion pattern and presence of caries or oral infection;

ii. A recommended referral to a dentist at one year of age;

iii. A mandatory referral for a child three years of age or older; and

iv. Dental inspection and prophylaxis, which shall be performed every six months until a child is 17 years of age and annually for any beneficiary 18 years of age or older who is eligible for EPSDT services.

4. Hearing services including the following:

i. A hearing screening for infants that shall include, at a minimum, an observation of an infant's response to auditory stimuli;

ii. A speech and hearing assessment, which shall be part of each preventive visit for an older child;

iii. An individual hearing screening, which shall be administered annually to all children through the age of eight and to all children at risk of hearing impairment;

iv. An individual hearing screening of each child every other year after the age of eight; and

v. An objective audiometric test, such as a pure-tone screening test, if performed as part of an EPSDT screening examination, shall be eligible for separate reimbursement.

5. Other medically necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

i. For requirements regarding community private duty nursing services for EPSDT beneficiaries, see N.J.A.C. 10:60-5.

(c) EPSDT screening services shall be provided periodically according to the following schedule, based on the age of the child:

1. Under six weeks;

2. Two months;

3. Four months;

4. Six months;

5. Nine months;

6. Twelve months;

7. Fifteen months;

8. Eighteen months;

9. Twenty-four months; and

10. Annually through 20 years of age.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote (a); in (b), changed N.J.A.C. reference; in (c), substituted references to beneficiaries for references to recipients throughout, and inserted a reference to NJ KidCare--Plan A fee-for-service beneficiaries and changed N.J.A.C. reference in 5i; and in (e)1iv(5), substituted "ova" for "oral" preceding "and parasites".

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare; and in (b)1iv, substituted ". The schedule can be found on the Centers for Disease Control (CDC) website at *http://www.cdc.gov/* or can be requested" for "(available", and deleted ")" following "30333".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.5

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.5 Family planning services

(a) Family planning services shall include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

(b) Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory, radiological and diagnostic services and surgical procedures shall not be covered services, except:

1. When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the hospital shall submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Provider Relations, PO Box 712, Mail Code #27, Trenton, New Jersey 08625-0712.

History

HISTORY:

New Rule, R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Former *N.J.A.C. 10:52-2.5*, Home health agencies; hospital-based, recodified to *N.J.A.C. 10:52-2.6*.

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

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

In (b), substituted "FamilyCare" for "KidCare-Plan A, B and C" in the introductory paragraph; in (f), deleted "Medical Affairs and" preceding "Provider Relations" and substituted "27" for "14" following "Mail Code #" in 1.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Deleted (b) through (e); and recodified (f) as (b).

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-2.6

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.6 Home health agencies; hospital-based

(a) A home health agency (hospital-based) shall be licensed by the New Jersey State Department of Health, certified as a home health agency under Title XVIII (Medicare), possess a valid and current provider agreement from the Division, and be an identifiable part of a hospital.

(b) The provision of home health care services can range from a complex concentrated professional program (for acute care cases) which would require the services of a public health nurse, registered professional nurse, a licensed practical nurse, physical therapist, occupational therapist, speech pathologist, medical social worker, and homemaker/home health aide to a less complex program (as in chronic care cases) involving a homemaker/ home health aide, personal care assistant and/or therapist and minimal visits by a registered nurse. The types of services provided, the frequency and the duration of these services are determined by the needs of each beneficiary. Only medically necessary home health services shall be reimbursed by the Division.

(c) Division requirements for Home Health Agencies (Hospital-based) are located in *N.J.A.C. 10:60*, Home Care Services. A hospital wishing to become a provider of home health services should contact Molina Medicaid Solutions Provider Enrollment, PO Box 4804, Trenton, NJ 08650, or the website *www.njmmis.com* and click on the Provider Enrollment Application. The application can be completed online or downloaded and mailed or faxed to Molina Medicaid Solutions at (609) 584-1192.

History

HISTORY:

Recodified from 10:52-2.5 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), substituted a reference to speech pathologists for a reference to speech-language pathologists, and substituted a reference to beneficiaries for a reference to recipients. Former *N.J.A.C. 10:52-2.6*, Medical day care centers; hospital affiliated, recodified to *N.J.A.C. 10:52-2.7*.

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

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

In (b), inserted "medical" preceding "social worker" in the first sentence, substituted "beneficiary" for "beneficiaries" following "each" in the second sentence and substituted "shall be" for "are" preceding "reimbursed" in the last sentence; rewrote (c).

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), substituted a comma for "and Senior Services;" following "Health", and substituted a comma for a semicolon following "(Medicare)" and following "Division"; and in (c), substituted "Molina Medicaid Solutions" for "Unisys" twice, and substituted "NJ" for "N.J.".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.7

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.7 Medical day care centers; hospital affiliated

(a) An adult or pediatric day health services facility shall be affiliated and identified as part of a hospital which is licensed by the New Jersey State Department of Health, in accordance with its Manual of Standards for Licensure of Adult and Pediatric Day Health Services and shall possess a valid and current provider agreement from the Division.

(b) Adult Day Health Services is a program of medically supervised, health-related services provided in a hospital affiliated ambulatory care setting to persons who are non-residents of the facility, who do not require 24-hour inpatient institutional care but, due to their physical or mental impairment, need health maintenance and restorative services to live in the community. Pediatric Day Health Services is a program which provides additional health-related services in order to provide for the needs of technology-dependent or medically unstable children.

(c) The Department of Health administers the Medicaid/NJ FamilyCare fee-for-service Adult Day Health Services and Pediatric Day Health Services programs. For program requirements, see *N.J.A.C. 8:86*.

1. Medical day care transportation services shall not be reimbursed by the fiscal agent as a separate service.

2. All direct and indirect costs associated with hospital-affiliated medical day care centers shall be reported separately on New Jersey State Department of Health cost filings for payment purposes and shall not be considered an allowable cost under the DRG reimbursement system.

(d) The Division shall not reimburse for medical day care services and partial hospitalization services provided to the same beneficiary on the same day.

History

HISTORY:

Recodified from 10:52-2.6 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote (c); in (d), substituted a reference to beneficiaries for a reference to recipients; and deleted a former (e). Former *N.J.A.C. 10:52-2.7*, Narcotic and drug abuse treatment centers; fee-standing, recodified to *N.J.A.C. 10:52-2.8*.

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

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

Rewrote (a), (b), and the introductory paragraph of (c).

§ 10:52-2.7 Medical day care centers; hospital affiliated

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), the introductory paragraph of (c), and (c)2, deleted "and Senior Services" following "Health"; and in the introductory paragraph of (c), substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-2.8

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.8 Substance use disorder treatment facilities; free-standing

(a) Division requirements for substance use disorder treatment facilities are located in *N.J.A.C. 10:66*, Independent Clinic Services. Services provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary by a free standing hospital-affiliated substance use disorder treatment facility shall be covered only if those services are eligible for Federal Financial Participation under the Medicaid Program (Title XIX of the Social Security Act) or the NJ FamilyCare program (Title XXI of the Social Security Act) and the following conditions are met:

1. The treatment is prescribed or certified by a physician or an advance practice nurse (APN); and

2. The treatment is provided in a substance use disorder treatment facility licensed or approved by the New Jersey State Department of Health pursuant to *N.J.S.A. 26:2G-21* et seq., and *N.J.A.C. 10:161A* for residential services, *N.J.A.C. 10:161B* for outpatient services, and/or N.J.A.C. 10:161B-11 for opioid treatment services, as applicable; and

3. The staff of the treatment facility includes a medical director.

(b) Payment for outpatient services provided in a free-standing substance use disorder treatment facility shall be made on a fee-for-service basis. The services include mental health services, methadone maintenance, and other related health services. The Division's payment shall be accepted as payment in full for Medicaid/NJ FamilyCare-Plans A and B. For NJ FamilyCare-Plan C, the Division's payment shall be considered as payment in full except for the Division's requirements regarding the personal contribution to care responsibilities of the NJ FamilyCare-Plan C beneficiaries which are codified at N.J.A.C. 10:49-9 and *10:52-4.7*. Mental health and substance use disorder services for beneficiaries of NJ FamilyCare-Plans A, B and C who are also clients of the Division of Developmental Disabilities are provided by their MCO.

(c) Inpatient and outpatient substance use disorder services for Plan D beneficiaries shall be limited to detoxification.

(d) Approved centers shall submit claims only for those procedure codes which correspond to the allowable services included in their New Jersey Medicaid/NJ FamilyCare provider approval letter. Room, board, and other residential services shall not be covered. Claims for reimbursement shall be submitted to the fiscal agent in an accepted format approved by the fiscal agent.

History

HISTORY:

Recodified from 10:52-2.7 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), inserted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries in the introductory paragraph; and rewrote (b). Former *N.J.A.C. 10:52-2.8*, Organ procurement and transplantation services, recodified to *N.J.A.C. 10:52-2.9*.

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

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

In (a), rewrote the introductory paragraph; rewrote (b); added a new (c); recodified former (c) as (d) and substituted "CMS 1500" for "1500 N.J." in the last sentence.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Substance abuse treatment centers; free-standing". Rewrote the section.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.9

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.9 Organ procurement and transplantation services

(a) The Division shall reimburse for medically necessary transplantation services, including organ procurement, except those transplants categorized as experimental. (See (d) below for further information on organ procurement and transplantation.)

1. Claims for transplant services and organ procurement services rendered to or items dispensed or furnished to an organ donor shall be submitted using the Health Benefits Identification Number of the Medicaid/NJ FamilyCare beneficiary who is receiving the transplant.

2. The organ donor's claim will be paid by the Medicaid/NJ FamilyCare program whether the claim is from the same hospital where the transplant service was provided to the Medicaid/NJ FamilyCare patient or from a different hospital.

(b) Federal organ procurement service requirements are listed in the Social Security Act, Section 1138 as amended by Section 9318(a) of the Omnibus Budget Reconciliation Act of 1986 (*42 U.S.C. § 1320*).

1. Organ procurement services, with the exception of bone marrow transplant and cornea procurement services, are covered only when the Organ Procurement Organization (OPO) meets the requirements as outlined in the Section 1138 of the Social Security Act (*42 U.S.C. § 1320 (b)*-8 Note) and when the OPO is designated and certified by the Secretary of the Department of Health and Senior Services and Human Services as the OPO for that geographical area in which the hospital is located.

(c) The covered organ transplantation procedures shall be performed in an organ transplant center approved or certified by a nationally recognized certifying or approving body, or one designated by the Federal government. In the absence of such a certification or approval of a nationally recognized body, the approval or certification, whichever applies, shall have been obtained from the appropriate body so charged in the State in which the organ transplant center is located.

(d) The candidate for transplantation shall have been accepted for the procedure by the transplant center. All out-of-State hospitalizations for transplantations shall require prior authorization from the Medical Assistance Customer Center (MACC) serving the beneficiary's county of residence.

(e) Organ transplantations shall be medically necessary. Transplantations, with the exception of cornea transplantations, shall be performed only to avert a potentially life-threatening situation for the patient.

1. If all factors pertinent to decision-making concerning the site of performance of a transplant procedure are essentially equal, preference shall be given to a New Jersey transplant center. However, Medicaid policy of equitable access also applies (see *42 CFR 431.52(c)*).

(f) For organ transplants for Medicaid/NJ FamilyCare beneficiaries enrolled with a managed care organization, the managed care organization shall be responsible for all costs, except for the costs of the hospital, for an individual placed on a transplant list while in the Medicaid/NJ FamilyCare fee-for-service program prior to enrollment in a managed care organization under contract with the Department of Human Services.

History

HISTORY:

Recodified from 10:52-2.8 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b)1 and (e), substituted references to beneficiaries for references to recipients throughout; in (e), substituted a reference to the Office of Health Service Administration for a reference to the Office of Medical Affairs and Provider Relations; and added (h). Former *N.J.A.C. 10:52-2.9*, Psychiatric services; partial hospitalization, recodified to *N.J.A.C. 10:52-2.10*.

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

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

Rewrote the section.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Rewrote (a)1; added (a)2; and in (f), deleted the last sentence.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a)1 and (f), made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-2.10

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.10 Psychiatric services; partial hospitalization

(a) Partial hospitalization (PH) means a psychiatric service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. A PH program shall provide, as listed below, a full system of services necessary to meet the comprehensive needs of the individual Medicaid/NJ FamilyCare fee-for-service beneficiary. These services shall include:

1. Assessment and evaluation;

2. Service procurement;

3. Therapy;

4. Information and referral;

5. Counseling;

6. Daily living education;

7. Community organization;

8. Pre-vocational therapy;

9. Recreational therapy; and,

10. Health-related services.

(b) Pre-vocational therapy, recreational therapy, and health related services, as required in (a) above, may be provided directly or arranged by partial hospitalization staff through other programs' elements or agencies. To avoid duplication of payment, these services shall not be billed separately from the claim submitted for partial hospitalization reimbursement.

(c) The requirements of the PH program shall include the following:

1. PH shall serve ambulatory, non-residential patients who spend only a part of a 24-hour period (a minimum of two hours and a maximum of five hours of active participation per day in active programming exclusive of meals) in the hospital.

2. A PH program shall be available daily for five days a week, with additional planned activities each week, during evening and/or weekend hours, as needed. Individual clients need not attend every day but as needed.

3. The staff of the PH program shall include a director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field, with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the PH program on a regularly scheduled basis. Other staff deemed necessary to implement a PH program shall include qualified mental health professionals, para-professionals, and volunteers.

(d) Authorization for PH services for individuals aged 18 and older who have no involvement with the Children's System of Care within the Department of Children and Families (DCF/CSOC), shall be obtained in accordance with *N.J.A.C. 10:52A*, Adult Acute Partial Hospital and Partial Hospital Services.

(e) Authorization for PH services for individuals under age 18, and individuals at or over the age of 18 and under the age of 21 who had been receiving services from the (DCF/CSOC) prior to their 18th birthday, shall be obtained as follows:

1. CSOC behavioral healthcare providers may include a referral for PH services in their plans of care. These referrals shall be submitted to the Contracted Systems Administrator (CSA) for approval.

2. If approved, the CSA shall provide the PH provider an authorization number to be used when requesting reimbursement from the Medicaid/NJ FamilyCare programs or any other entities designated by DCBHS to provide reimbursement.

3. Authorization for PH services shall not exceed six months without written permission from CSOC or the CSA.

4. For lengths of stay in the PH program exceeding six months, requests for authorization shall be considered on a case-by-case basis by the DCF or the CSA. The request for authorization shall include sufficient documentation to indicate progress previously made towards the defined treatment goals and justification for the need for continued PH services. In no case shall continued authorizations for PH services exceed 12 months without a discharge plan that provides for a transition to other community-based interventions and supports within the following three months.

(f) Mental health services provided by or through the partial hospitalization program shall not include:

1. Student education, including preparation of school-assigned classwork or homework; or

2. Incentive programs, including, but not limited to, non-therapeutic token economies and subcontract work responsibilities.

(g) The Division shall not reimburse a hospital and/or any other provider for providing both PH services and medical day care center services to the same beneficiary on the same day.

(h) The Division shall not reimburse a hospital for any mental health service (including medication management) provided in addition to PH services provided to the same beneficiary on the same day.

(i) Additional requirements related to Partial Hospitalization (PH) services and Adult Acute Partial Hospitalization (APH) services available to eligible Medicaid/NJ FamilyCare beneficiaries age 18 and older are found at *N.J.A.C. 10:52A*.

History

HISTORY:

Recodified from 10:52-2.9 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph; and in (d), substituted a reference to the Division's fiscal agent for a reference to the Medicaid fiscal agent and added a reference to NJ KidCare in 4, and substituted references to beneficiaries for references to recipients in 5 and 6. Former *N.J.A.C. 10:52-2.10*, Rehabilitative services; hospital outpatient department, recodified to *N.J.A.C. 10:52-2.11*.

Special amendment, R.2002 d.82, effective February 15, 2002 (to expire December 21, 2004).

See: *34 N.J.R. 1279(a)*.

Rewrote (c)1i; in (d), inserted ", except as provided in (e) below"; added (e).

Special amendment, R.2002 d.191, effective May 24, 2002 (to expire December 21, 2004).

See: *34 N.J.R. 2149(a)*.

In (c), rewrote 1i; in (d), substituted "30" for "90" and deleted ", except as provided in (e) below"; deleted (e).

Amended by R.2003 d.182, effective May 5, 2003.

See: *34 N.J.R. 4303(a)*, *35 N.J.R. 1901(a)*.

Rewrote (d)2.

Amended by R.2004 d.75, effective February 17, 2004.

See: *35 N.J.R. 2154(a)*, *36 N.J.R. 952(b)*.

In (d), inserted a new 7; added (e).

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

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

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service" in the introductory paragraph; in (d), deleted former 3, recodified former 4 as 3 and substituted "FamilyCare" for "KidCare", and recodified former 5 through 7 as 4 through 6.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (c)1, substituted "two" for "three" and "and a maximum" for "of participation in active programming for a half day program exclusive of meals and a minimum", inserted "per day", and deleted "for a full day program" preceding "exclusive of meals)"; deleted (c)1i; rewrote (d); added new (e) and (g) through (i); and recodified former (e) as (f).

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a), substituted "Medicaid/NJ" for "Medicaid or NJ"; and rewrote (d) and (e).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.10A

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.10A Psychiatric services; partial hospitalization prevocational programs

(a) The provisions of this section shall apply when prevocational services are provided within a partial hospitalization program, in accordance with *N.J.A.C. 10:52-2.10(a)*8.

(b) The following words and terms, when used in this chapter, shall have the following meanings, unless the context indicates otherwise:

"Mental health services worker" means an individual who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

"Prevocational services" means interventions, strategies, and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes, and skills needed to take on the role of worker and in other life domains, such as: responding to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms, and adherence to prescribed medication directions/schedules. Examples of interventions not considered prevocational or covered by Medicaid/NJ FamilyCare include: technical occupational skills training, college preparation, student education, including preparation of school assigned classwork or homework and individualized job development.

"Special minimum wage certificate" means a certificate issued by the U.S. Department of Labor pursuant to 29 C.F.R. § 525, which permits a worker with a disability to be paid at a rate below the rate which would otherwise be required by statute.

"Therapeutic subcontract work activity" means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program by the U.S. Department of Labor.

"Vocational services" means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(c) The Division will reimburse a provider for prevocational services provided within the context of a partial hospitalization program, in accordance with this section.

(d) Prevocational services shall be those interventions, strategies and activities within the context of a partial hospitalization program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as responding appropriately to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and medication adherence. Services or interventions which are not considered prevocational will

not be reimbursed by the Medicaid/NJ FamilyCare programs. Examples of services or interventions not considered to be prevocational include:

1. Technical or occupational skills training;

2. College preparation;

3. Student education, including preparation of school-assigned classwork or homework; and

4. Individualized job development.

(e) The Division will not reimburse any provider for vocational services provided within the context of a partial hospitalization program.

1. Vocational services means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(f) When, in the judgment of the treatment team, an individual is appropriate for discharge or referral to another employment-related service provider or situation, and, has demonstrated mastery of individualized goals and objectives, such as: an ability to respond appropriately to criticism, make decisions, negotiate for needs, deal with interpersonal issues, manage psychiatric symptoms and adhere to medication prescriptions, the service provider shall:

1. Update the individual treatment goal;

2. Revise the discharge plan; and

3. Refer the individual to a community work setting, if such referral is appropriate for the individual.

(g) The Division will reimburse prevocational services provided to eligible beneficiaries within the context of a partial hospitalization program when the services consist of therapeutic subcontract work activity, and when all of the following requirements are met:

1. The therapeutic subcontract work activity shall consist of production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage, and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program, by the U.S. Department of Labor;

2. The individuals plan of care shall contain a stipulation that the therapeutic subcontract work activity is a form of intervention intended to address the individual deficits of the patient as identified in the clients assessment;

3. The therapeutic subcontract work activity shall be facilitated by a qualified mental health services worker;

4. The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health services worker; and

5. The staff to client ratio shall not exceed a ratio of 1:10 qualified mental health services worker to client.

History

HISTORY:

New Rule, R.2004 d.75, effective February 17, 2004.

See: *35 N.J.R. 2154(a)*, *36 N.J.R. 952(b)*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (b), in definition "Prevocational services", inserted a comma following "strategies", following "attitudes", and following "symptoms", and substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-2.11

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.11 Rehabilitative services; hospital outpatient department

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

1. "Rehabilitative services" means physical therapy, occupational therapy, speech pathology and audiology services, and the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services and other restorative services shall be provided for the purpose of attaining maximum reduction in disability and restoration of a Medicaid beneficiary to his or her highest possible functional level. Rehabilitative services shall be made available to Medicaid/NJ FamilyCare beneficiaries as an integral part of a comprehensive medical program.

2. "Occupational therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist. These services include necessary supplies and equipment.

3. "Qualified occupational therapist" means an individual who is:

i. Registered by the American Occupational Therapy Association (AOTA); or,

ii. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association. If treatment and/or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure, if applicable, and shall also meet all applicable Federal requirements.

4. "Physical therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified physical therapist. These services include necessary supplies and equipment.

5. "Qualified physical therapist" means an individual who is:

i. Licensed by the State of New Jersey as a physical therapist in accordance with *N.J.A.C. 13:39A*;

ii. A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and

iii. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

6. "Speech-language pathology" and "audiology services" mean diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech-language pathologist or audiologist. The services include necessary supplies and equipment.

7. "Speech-language pathologist" or "audiologist" means an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with *N.J.A.C. 13:44C*, and who meets all applicable Federal requirements including:

i. A certificate of clinical competence in Speech-Language Pathology (CCC-SLP) or Audiology (CCC-A) from the American Speech-Language-Hearing Association (American Speech-Language-Hearing Association, 2200 Research Blvd., Rockville, MD 20850-5650, or *http://www.asha.org*); or completion of the equivalent educational requirements and work experience necessary for the certificate; or completion of the academic program and is in the process of acquiring supervised work experience in order to qualify for the certificate;

ii. If treatment or services are provided in a state other than New Jersey, the speech-language pathologist or audiologist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements;

iii. If the attending physician orders an evaluation for speech-language therapy, the speech-language pathologist may make an initial visit for a screening examination. If, as a result of the screening examination, a comprehensive evaluation is necessary, the comprehensive evaluation shall be completed at the same time as the screening examination, or at the earliest mutual convenience of the patient and the provider;

iv. An initial comprehensive speech-language pathology evaluation should last approximately three hours, and shall include, as an integral part of the evaluation, a written report, as well as discussion and consultation with the patient or family, or both, regarding the findings; and

v. The Division shall reimburse for either a screening examination or a comprehensive speech-language evaluation rendered to a beneficiary, but not both. If the documentation reveals that the screening examination did not support the need for a comprehensive evaluation, the request for reimbursement will be downgraded to Speech-Language Therapy--Initial Visit Screening Examination, and reimbursed accordingly.

(b) All treatment services shall be prescribed by a physician or other medical practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe rehabilitative services within the scope of his or her license and practice and be provided by or under the direction or personal supervision of the appropriate qualified practitioner of the healing arts.

(c) A plan of treatment shall be completed during the beneficiary's initial evaluation visit for rehabilitative service(s) and shall be retained on file.

1. The plan of treatment shall be definitive as to the modality, amount of time per treatment, frequency and duration of the rehabilitative services to be furnished. The beneficiary's diagnosis and the anticipated goal(s) of the treatment shall be included in the treatment plan.

(d) A re-evaluation shall be performed at the end of a course of treatment to determine the need to continue with or change the treatment modality.

History

HISTORY:

Recodified from 10:52-2.10 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote the section. Former *N.J.A.C. 10:52-2.11*, Renal dialysis services for end-stage renal disease (ESRD), recodified to *N.J.A.C. 10:52-2.12*.

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

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

Rewrote the section.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a)7i, substituted "2200 Research Blvd., Rockville, MD 20850-5650" for "10801 Rockville Pike, Rockville, MD 20852", and deleted "and" from the end; in (a)7iv, inserted "and" at the end; and rewrote (b).

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a)2 and (a)4, substituted "Medicaid/NJ" for "Medicaid or NJ".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.12

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.12 Renal dialysis services for end-stage renal disease (ESRD)

(a) A hospital outpatient renal dialysis center shall be approved by the New Jersey State Department of Health to provide renal dialysis treatment for ESRD.

(b) At the beginning of a maintenance course of renal dialysis treatment for ESRD, renal dialysis centers should direct their Medicaid/NJ FamilyCare fee-for-service beneficiary to the Social Security Administration District Office to file an application for Medicare benefits, if applicable.

(c) Renal dialysis services for ESRD and Medicare approved "add-on" costs shall be reimbursable by Medicaid/NJ FamilyCare fee-for-service only when the individual is a Medicaid/NJ FamilyCare fee-for-service beneficiary and not a Medicare beneficiary, or during the time frame when ESRD services are not Medicare reimbursable.

1. Medicare coverage usually begins with the first day of the third month after the month in which a maintenance course of renal dialysis services begins. Claims from that date on shall be submitted to Medicare, unless the Medicaid/NJ FamilyCare fee-for-service beneficiary has been denied eligibility for Medicare.

i. Exception: Medicare coverage may begin earlier than the time frame stated above if the individual receives renal transplantation services or participates in a self-dialysis training program.

(d) Reimbursement for hospital inpatient renal dialysis services for ESRD are included in the DRG rates.

History

HISTORY:

Recodified from 10:52-2.11 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients/patients; and in (c), substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare fee-for-service throughout. Former *N.J.A.C. 10:52-2.12*, Sterilization, recodified to *N.J.A.C. 10:52-2.13*.

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

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

In (c), substituted "services" for "benefits" preceding "are not Medicare reimbursable" in the introductory paragraph; substituted "FamilyCare" for "KidCare" preceding "fee-for-service" throughout.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (d), substituted "rates" for "rate methodology determinations".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), deleted "and Senior Services" following "Health"; and in (b) and (c), substituted "Medicaid/NJ" for "Medicaid or NJ" throughout.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.13

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.13 Sterilization

(a) The Division covers sterilization procedures performed on Medicaid/NJ FamilyCare fee-for-service beneficiaries based on Federal regulations (*42 CFR 441.250* through *441.258*) and related requirements outlined in this section and in the billing instructions contained in the Fiscal Agent Billing Supplement. For sterilization policy and procedures, see (b) through (e) below.

(b) "Sterilization" means any medical procedure, treatment, or operation, performed for the purpose of rendering an individual permanently incapable of reproducing. Surgical sterilization procedures are considered to be those whose primary purpose is to render an individual incapable of reproducing. Such procedures require the completion of the Federal "Consent Form" for sterilization.

(c) "Consent Form"--(Pursuant to *42 CFR 441.258*--Appendix to Subpart F--Specific Requirements for Use) requirements, including time frames to be met and/or documented on the "Consent Form" prior to the sterilization of an individual, follow:

1. The individual shall be at least 21 years of age at the time the consent is obtained;

2. The individual shall not be mentally incompetent. A "mentally incompetent individual" means an individual who has been declared mentally incompetent by a Federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization;

3. The individual shall not be institutionalized. An "institutionalized individual" means an individual who is:

i. Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or,

ii. Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness;

4. The individual shall have voluntarily given informed consent;

5. At least 30 days, but not more than 180 days, shall have passed between the date of informed consent and the date of sterilization, except in the case of emergency abdominal surgery or premature delivery;

i. In the case of emergency abdominal surgery, at least 72 hours shall have passed between the date he or she gave informed consent and date of sterilization;

ii. In the case of premature delivery, informed consent shall have been given at least 30 days before the expected date of delivery and at least 72 hours have passed between the date of informed consent and the date of premature delivery.

6. In the case where a patient desires to be sterilized at the time of delivery, the "Consent Form" shall be signed by the patient no earlier than the 5th month of pregnancy to minimize the possibility of exceeding the 180 day limit.

(d) An individual shall be considered to have given informed consent only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had or has concerning the procedure, provided a copy of the "Consent Form", and provided orally all of the following information or advice to the individual to be sterilized; and,

i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled; and,

ii. A description of available alternative methods of family planning birth control; and,

iii. Advice that the sterilization procedure is considered to be irreversible; and,

iv. A thorough explanation of the specific sterilization procedure to be performed; and,

v. A full description of the discomfort and risks that may accompany or follow the performing of the procedure, including an explanation of type and possible effects of any anesthetic to be used; and,

vi. A full description of the benefits or advantages that may be expected as a result of the sterilization; and,

vii. Advice that the sterilization will not be performed for at least 30 days except for emergency abdominal surgery or premature delivery.

2. Suitable arrangements were made to insure that the information specified above under "Informed Consent" was effectively communicated to any individual who is blind, deaf, or otherwise handicapped; and,

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the "Consent Form" or the language used by the person obtaining consent; and,

4. The individual to be sterilized was permitted to have a witness of his or her own choice present when consent was obtained; and,

5. The requirements of the "Consent Form" were met, that is, its contents, certification, and signatures (see (e) below). The consent form currently in use by the Division is a replica of the form contained in the Federal regulations and shall be utilized by providers when submitting claims. No other consent form shall be permitted, unless approved by the Secretary, United States Department of Health and Human Services. The form is available from the Division's fiscal agent.

(e) Required consent form information, signatures, certification, and dates: In addition to completing all information (name of doctor or clinic the patient received information from, name of the operation to be performed, the patient's birth date, name of the patient, name of the physician who will perform the sterilization, the method, the language used by an interpreter, name and address of the facility the person obtaining consent is associated with, the date of the sterilization and the specific type of operation) in the appropriate spaces provided, the form shall be signed and dated by hand by the person indicated below:

1. "Consent to Sterilization," by the individual to be sterilized, prior to the sterilization operation (in accordance with the time frames specified in (c)5. above.

2. "Interpreter's Statement," by the interpreter, if one was provided prior to the sterilization operation. The interpreter must certify by signing and dating the "Consent Form" that:

i. He or she translated the information presented orally and read the "Consent Form" and explained its contents to the individual to be sterilized; and,

ii. To the best of the interpreter's knowledge and belief, the individual understood what the interpreter told him or her.

3. "Statement of Person Obtaining Consent," by the person who obtained the consent prior to the sterilization operation. The person securing the consent must certify, by signing and dating the "Consent Form" that:

i. Before the individual signed the "Consent Form", he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized; and,

ii. He or she explained orally the requirements for informed consent as set forth on the "Consent Form"; and

iii. To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized. The name and address of the facility or physician's office with which the person obtaining consent is associated must be completed in the space provided on the form.

4. "Physician's Statement," by the physician who performed the sterilization operation after the surgery had been performed. (A date prior to surgery is not acceptable.) The physician performing the sterilization shall certify, by signing and dating the "Consent Form," that within 24 hours before the performance of the sterilization operation:

i. The physician advised the individual to be sterilized that no Federal benefits may be withdrawn from the patient because of the decision not to be sterilized; and,

ii. The physician explained orally the requirements for informed consent as set forth on the "Consent Form"; and,

iii. To the best of the physician's knowledge and belief, the individual appeared mentally competent and knowingly and voluntarily consented to be sterilized; and,

iv. That at least 30 days have passed between the date of the individual's signature on the "Consent Form" and certified that the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature delivery; and,

v. In the case of emergency abdominal surgery or premature delivery performed within 30 days of consent, the physician shall certify that the sterilization was performed less than 30 days, but not less than 72 hours after informed consent was obtained, and in the case of abdominal surgery must describe the emergency, or in the case of premature delivery, must state the expected date of delivery.

5. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

6. Informed consent shall not be obtained while the individual to be sterilized is:

i. In labor or childbirth; or,

ii. Seeking to obtain or obtaining an abortion; or,

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness.

(f) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB-92 claim form (including inpatient or outpatient) for all sterilization claims with the "Consent Form" attached to the UB-92 claim form and not submit the claim through the EMC claim processing system.

History

HISTORY:

Recodified from 10:52-2.12 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to Medicaid and NJ KidCare--Plan A, B or C fee-for-service beneficiaries for a reference to Medicaid recipients; and in (b), substituted a reference to medical procedures for a reference to surgical procedures. Former *N.J.A.C. 10:52-2.13*, Hysterectomy, recodified to *N.J.A.C. 10:52-2.14*.

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

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

In (a), substituted "FamilyCare" for "KidCare-Plans A, B or C" preceding "fee-for-service" and deleted "42 CFR" preceding "441.258".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), substituted "Medicaid/NJ" for "Medicaid or NJ", and inserted "Federal regulations (" and ")".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.14

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.14 Hysterectomy

(a) The Division covers hysterectomy procedures performed on Medicaid/NJ FamilyCare fee-for-service beneficiaries based on Federal regulations (*42 CFR 441.250* through *441.258*) and related requirements outlined in this section and in the billing instructions. For hysterectomy requirements see (b) through (d) below. In addition, see *N.J.A.C. 10:52-1.13* for the requirements for a Second Surgical Opinion for performing a hysterectomy.

(b) "Hysterectomy" means an operation for the purpose of removing the uterus.

1. A hysterectomy shall not be performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy shall be covered as a surgical procedure if performed primarily for the purpose of removing a pathological organ.

(c) Surgical hysterectomy procedures claim processing and reporting require the completion of the "Hysterectomy Receipt of Information Form (FD-189)" or, under certain conditions (see (d)1iii below), a physician certification. A second opinion shall be obtained and shall be submitted with the claim.

(d) The specific requirements to be met or documented on the "Hysterectomy Receipt of Information," (FD-189) form or, under certain conditions, a physician certification, shall be as follows:

1. A hysterectomy on a female of any age may be performed when medically necessary for a pathological indication, provided the person who secured authorization to perform the hysterectomy has:

i. Informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and,

ii. Ensures that the FD-189 form is completed and the individual or her representative has signed and dated a written acknowledgement of receipt of that information utilizing the FD-189 form; or,

iii. The physician who performed the hysterectomy certifies, in writing, that the individual:

(1) Was sterile before the hysterectomy (include cause of sterility); or,

(2) Required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible (include a description of the nature of the emergency); or,

(3) Was operated on during a period of the person's retroactive Medicaid/NJ FamilyCare-Plan A eligibility and the individual was informed, before the operation, that the hysterectomy would make her permanently incapable of reproducing or one of the conditions described in (d)1iii(1) or (2) above was applicable. (Include a statement that the individual was informed or describe which condition was applicable). "Retroactive Medicaid eligibility" means the consideration of unpaid medical bills incurred during a three-month period prior to the month the person applied for assistance. (See *N.J.A.C. 10:49-2.9*, Administration.) Although a physician certification is acceptable for situations described in (d)1iii above, the Division recommends that the FD-189

form be used whenever possible. There is no 30-day waiting period required before a medically necessary hysterectomy may be performed. The standard procedure for a surgical informed consent form within the hospital will suffice.

(e) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB-92 claim form for all hysterectomy claims with the FD-189 form attached to the claim form and must not submit the claim through the EMC claim processing system.

History

HISTORY:

Recodified from 10:52-2.13 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients, and changed N.J.A.C. reference; and in (d)1iii(3), inserted a reference to NJ KidCare--Plan A eligibility. Former *N.J.A.C. 10:52-2.14*, Termination of pregnancy, recodified to *N.J.A.C. 10:52-2.15*.

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

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

Rewrote (a); in (c), deleted ", Rev. 7/83" preceding "(FD-189" and added the second sentence; in (d), deleted ", Rev. 7/83" preceding "(FD-189" in the introductory paragraph, and substituted "FamilyCare" for "KidCare", amended the N.J.A.C. reference and substituted "suffice" for "prevail" in 1iii(3).

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), substituted "Medicaid/NJ" for "Medicaid and NJ"; and in (d)1iii(3), substituted "Medicaid/NJ" for "Medicaid or NJ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-2.15

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.15 Termination of pregnancy

(a) The Division shall reimburse for medically necessary termination of pregnancy procedures on Medicaid/NJ FamilyCare beneficiaries when performed by a physician in accordance with *N.J.A.C. 13:35-4.2*. These services are reimbursed fee-for-service for all beneficiaries, including individuals enrolled in an MCO.

(b) A physician may take the following factors into consideration in determining whether a termination of pregnancy is medically necessary:

1. The termination of the pregnancy is necessary to save the life of the mother;

2. The pregnancy was the result of an act of rape;

3. The pregnancy was the result of an act of incest; or

4. In the physician's professional judgment, the termination was medically necessary, consistent with the following factors:

i. Physical, emotional, and psychological factors;

ii. Family reasons; and

iii. The age of the mother.

(c) The determination of medical necessity is subject to review by the Division in accordance with the rules of the Division. In addition, the procedure must be performed consistent with *N.J.A.C. 13:35-4.2*.

(d) A "Physician Certification (Form FD-179)" shall be attached to the hospital's Medicaid claim form, either for inpatient or outpatient services, if any of the procedures on the claim relate to a voluntary elective abortion.

i. A copy of the completed FD-179 shall also be attached to:

(1) The physician's Medicaid claim form; and,

(2) The anesthesiologist's Medicaid claim form.

(e) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB-92 claim form (inpatient or outpatient) for all termination of pregnancy claims with the "Physician Certification (Form FD-179)" attached to the UB-92 claim form and must not submit the claim through the electronic billing system.

History

HISTORY:

Recodified from 10:52-2.14 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to Medicaid and NJ KidCare beneficiaries for a reference to Medicaid recipients, and added a second sentence; and in (c), substituted references to the Division for references to the Medicaid program throughout. Former *N.J.A.C. 10:52-2.15*, Transportation services; hospital-based, recodified to *N.J.A.C. 10:52-2.16*.

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

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

In (a), substituted "FamilyCare" for "KidCare" preceding "beneficiaries when performed by a physician"; rewrote (b).

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), substituted "Medicaid/NJ" for "Medicaid or NJ" and "MCO" for "HMO", and deleted "the New Jersey Administrative Code," preceding "N.J.A.C.".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-2.16

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

§ 10:52-2.16 Transportation services; hospital-based

(a) Transportation shall be recognized by the Division as a covered outpatient hospital service under the following conditions:

1. Hospital-based emergency ambulance service for inpatient admission or outpatient services. For the definition of "emergency conditions", see *N.J.A.C. 10:49-6.1*, Administration, Prior and Retroactive Authorization.

2. When a hospital is under contract with a municipality, county, or other government unit, to provide "911" or rescue squad ambulance service, reimbursement shall only be permitted on a fee-for-service basis under the policies and procedures as defined in *N.J.A.C. 10:50-1.2*, Transportation Services.

3. Each hospital providing ambulance service to Medicaid/NJ FamilyCare fee-for-service beneficiaries shall possess all of the following:

i. An approved certificate of need for ambulance service from the New Jersey State Department of Health; and

ii. A provider license and vehicle license(s) for ambulance service from the New Jersey State Department of Health.

(b) Mobile Intensive Care Unit/Advanced Life Support (MICU/ALS) service and associated Ambulance/Basic Life Support (Ambulance/BLS) service shall be considered covered services under the following conditions of participation:

1. A hospital shall possess a "Certificate of Need" from the New Jersey State Department of Health and Senior Services to provide MICU/ALS service;

2. A hospital shall complete a "Memorandum of Understanding," issued by the Division of Medical Assistance and Health Services, before reimbursement can be made to the hospital for this service. The "Memorandum of Understanding" may be obtained from and, when completed, shall be returned to the Division of Medical Assistance and Health Services, Provider Enrollment Unit, PO Box 712, Mail Code #9, Trenton, New Jersey 08625-0712;

3. A hospital providing MICU/ALS service without its own associated Ambulance/BLS service or MICU/ALS transport vehicle, may utilize the service of a volunteer ambulance organization or shall enter into an agreement(s) with a proprietary/nonproprietary Ambulance/BLS company for the purpose of defining the responsibility for service. No reimbursement shall be made when the Ambulance/BLS Service is provided by a volunteer ambulance organization.

i. A copy of the agreement(s) shall be sent to the Division of Medical Assistance and Health Services, PO Box 712, Provider Enrollment Unit, Mail Code #9, Trenton, New Jersey 08625-0712.

ii. The hospital shall bill for the Ambulance/BLS service only upon completion of an agreement.

iii. In the absence of an agreement(s) between the hospital providing the MICU/ALS service and a proprietary/nonproprietary Ambulance/BLS company, the hospital shall bill the Division's fiscal agent for the MICU/ALS service only.

iv. Transportation companies providing Ambulance/BLS associated with, and/or in conjunction with a MICU/ALS service, shall bill charges to the hospital providing the MICU/ALS service.

(c) Medicaid/NJ FamilyCare fee-for-service reimbursement of MICU/ALS services shall be based on Medicare principles of reimbursement, using standard cost reporting procedures, and reasonable cost and charge guidelines.

(d) Reimbursement for transportation services to and from hospital-affiliated medical day care centers are included in the medical day care per diem rate and shall not be billed to the New Jersey Medicaid/NJ FamilyCare program by the hospital separately.

(e) Transportation of inpatient beneficiaries transferred to another facility to receive services not available at the sending location, whether the intent is for the beneficiary to return or not, shall be the responsibility of the sending facility. These costs shall be included in the inpatient claim.

History

HISTORY:

Recodified from 10:52-2.15 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a)4, substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph; in (c), inserted a reference to NJ KidCare fee-for-service reimbursement; and in (d), added "and shall not be billed to the New Jersey Medicaid or NJ KidCare--Plan A program by the hospital separately".

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

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

Substituted references to FamilyCare for references to KidCare throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.1

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.1 Purpose

The purpose of HealthStart shall be to provide comprehensive maternity care services to pregnant Medicaid/NJ FamilyCare fee-for-service beneficiaries, (including those determined to be presumptively eligible) and preventive child health care services for Medicaid/NJ FamilyCare fee-for-service beneficiaries up to the age of two.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Inserted a reference to NJ KidCare--Plan A beneficiaries.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Substituted "Medicaid/NJ" for "Medicaid and NJ" twice.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.2

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.2 Scope of services

(a) HealthStart maternity care services provided by a HealthStart-certified provider shall be obstetrical care services provided in accordance with the recommendations of the American College of Obstetricians and Gynecologists and a program of support services provided in accordance with the New Jersey Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," dated 1997, available from the Department of Health.

(b) HealthStart comprehensive maternity care includes both medical maternity care services and health support services, which are described in (b)1 and 2 below:

1. Medical maternity care services shall include, but shall not be limited to:

i. Ambulatory prenatal services;

ii. Admission arrangements for delivery;

iii. Obstetrical delivery services; and

iv. Postpartum medical services.

2. Health support services shall include, but shall not be limited to:

i. Case coordination services;

ii. Health education assessment and counseling services;

iii. Nutrition assessment and counseling services;

iv. Social-psychological assessment and counseling services;

v. Home visitation; and

vi. Outreach, referral and follow-up services.

(c) HealthStart preventive child health care services include nine preventive child health visits, all the recommended immunizations, case coordination and continuity of care, including, but not limited to, the provision or arrangement for sick care, 24-hour telephone access, and referral and follow-up for complex or extensive medical, social, psychological and nutritional needs.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), substituted "Health's" for "Health and Senior Services' ", and deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.3

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.3 HealthStart provider participation criteria

(a) The following Medicaid/NJ FamilyCare fee-for-service-enrolled provider types shall be eligible to participate as HealthStart providers:

1. Independent clinics;

2. Federally qualified health centers;

3. Hospital outpatient departments;

4. Local health departments;

5. Physician groups; and

6. Certified nurse midwives meeting the New Jersey Department of Health's Improved Pregnancy Outcome criteria.

(b) In addition to New Jersey Medicaid/NJ FamilyCare fee-for-service programs' rules applicable to provider participation, HealthStart providers shall:

1. Sign an Addendum to the New Jersey Medicaid /NJ FamilyCare fee-for-service programs' Provider Agreement;

2. Have a valid HealthStart Provider Certificate for HealthStart Comprehensive Maternity Care, HealthStart Obstetrical Care, HealthStart Health Support Services; and

3. Provide maternity care in accordance with the requirements for issuance of a "HealthStart Certificate," and in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(c) In addition to (a) and (b) above, HealthStart maternity care providers with more than one care site or more than one maternity clinic at the same site that use different staff shall apply for a separate HealthStart Comprehensive Maternity Provider Certificate for each separate clinic. Only those sites which hold a HealthStart Comprehensive Maternity Provider Certificate shall be reimbursed for HealthStart services. Such sites:

1. Shall participate in program evaluation and training activities, including, but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to the New Jersey Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines"; and

2. May determine presumptive eligibility for New Jersey Medicaid/NJ FamilyCare fee-for-service programs, if approved by the Division of Medical Assistance and Health Services.

(d) In addition to (a) and (b) above, HealthStart pediatric care providers shall participate in program evaluation and training activities including, but not limited to, documentation of outreach and follow-up activities in the patient's record.

(e) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Comprehensive Maternity Provider Certificate and to provide services in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(f) A HealthStart Comprehensive Maternity Provider Certificate shall be reviewed by the New Jersey State Department of Health at least every 18 months from the date of issuance.

(g) An application for a HealthStart Comprehensive Maternity Provider Certificate is available from:

HealthStart Program

New Jersey State Department of Health

PO Box 364

Trenton, NJ 08625-0364

(h) A HealthStart Program Provider Agreement is available from:

Chief, Provider Enrollment Unit

Division of Medical Assistance

and Health Services

Mail Code #9

PO Box 712

Trenton, New Jersey 08625-0712

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid, NJ FamilyCare, and the Department of Health throughout; and in (b)3, moved the end quote from preceding the period at the end to following it.

Annotations

Notes

Chapter Notes

§ 10:52-3.3 HealthStart provider participation criteria

End of Document

N.J.A.C. 10:52-3.4

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.4 Termination of HealthStart Comprehensive Maternity Provider Certificate

(a) The New Jersey State Department of Health shall enforce its requirements for HealthStart Comprehensive Maternity Provider Certificates and for evaluation and enforcement of its requirements within the standards and guidelines for HealthStart providers.

(b) Failure to comply with HealthStart standards shall be cause for termination of the HealthStart Comprehensive Maternity Provider Certificate by the New Jersey State Department of Health.

1. A HealthStart Comprehensive Maternity Provider Certificate shall be time-limited. Failure to complete the recertification process shall result in termination of the provider's HealthStart provider status by the New Jersey State Department of Health.

2. Termination of the HealthStart Comprehensive Maternity Provider Certificate shall result in the termination of the HealthStart Provider Agreement with the Medicaid NJ FamilyCare fee-for-service program. Providers who are terminated shall have the right to request a hearing in accordance with N.J.A.C. 10:49-10.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted "and Senior Services" following "Health" throughout.

Annotations

Notes

§ 10:52-3.4 Termination of HealthStart Comprehensive Maternity Provider Certificate

Chapter Notes

End of Document

N.J.A.C. 10:52-3.5

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate

(a) Comprehensive maternity care services shall be integrated and coordinated.

(b) HealthStart maternity care providers, excluding physicians and nurse midwives who are in private practice, shall provide comprehensive maternity care services within the following organizational requirements:

1. Providers shall provide directly or through an approved agreement, at one contiguous site, the following services: ambulatory prenatal and postpartum care; case coordination services; nutrition assessment; guidance and counseling services; health education assessment and instruction; and social-psychological assessment, guidance and counseling;

2. Providers shall provide or arrange for the admission of patients to the appropriate level of care facility for obstetrical care delivery services;

3. Providers shall provide or arrange for all necessary laboratory services;

4. Providers shall provide one or more prenatal home visits for each high risk patient;

5. Providers shall provide at least one postpartum home visit for each high risk patient;

6. Providers shall adopt policies and procedures to assure the delivery of coordinated, integrated and comprehensive care; and

7. Providers shall provide referral and follow-up services, which shall include, but shall not be limited to: referral for specialized evaluations, counseling and treatment for extensive social, psychological, nutritional and medical needs.

(c) A provider shall link the mother and newborn infant with a pediatric care provider.

(d) An independent clinic may provide the HealthStart health support services component alone upon entering into a written agreement with a private practitioner(s) who shall provide the HealthStart medical care services component. This agreement shall delineate which party shall take primary responsibility for provision of all HealthStart services.

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-3.6

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.6 Access to services

(a) All HealthStart services shall be accessible to patients.

(b) HealthStart maternity care providers shall facilitate patient access to services by scheduling an initial medical visit appointment within two weeks of the patient's first request for services.

(c) HealthStart maternity care providers shall provide or arrange for 24-hour access to case coordination and medical services for emergency situations.

(d) HealthStart maternity care providers shall arrange for language translation or interpretation services.

(e) HealthStart maternity care providers may implement presumptive eligibility processing if so approved by the Division of Medical Assistance and Health Services.

(f) HealthStart maternity care providers shall undertake community outreach activities to encourage women to seek early prenatal care and increase awareness of the availability of maternity care services.

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

In (b), inserted "medical visit" preceding "appointment"; in (e), substituted "processing if so" for "determinations if" following "presumptive eligibility".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.7

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.7 Plan of care

(a) A plan of care shall be developed and maintained by the case coordinator for each patient.

(b) A plan of care shall be based on the medical, nutritional, social-psychological and health education assessments.

(c) A plan of care shall include, but shall not be limited to: identification of risk conditions and problems, prioritization of needs, outcome objectives, planned interventions, time frames, referrals, follow-up activities and identification of staff responsible for the services.

(d) The plan of care shall be developed and revised in consultation with the patient and staff providing services to the patient.

(e) The initial plan of care shall be completed after a case conference and no later than one month after the initial registration visit.

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

In (c), inserted "shall" preceding "not be limited to" and substituted "referrals, follow-up activities and identification of staff responsible" for "referrals and follow-up activities, and identification of staff persons responsible"; substituted "plan of care" for "PoC" throughout.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.8

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.8 Maternity medical care services

(a) Maternity medical care services shall include antepartum, intrapartum, and postpartum care provided by the obstetrical care practitioner(s) in accordance with New Jersey State Department of Health's HealthStart Comprehensive Maternity Care Services Program Guidelines.

(b) Prenatal services shall be as follows:

1. Frequency of prenatal visits for an uncomplicated pregnancy shall be every four weeks during the first 28 weeks; then every two weeks until 36 weeks; and weekly thereafter. Prenatal visits for complications shall be scheduled as needed.

2. Initial prenatal visit content shall include, but not be limited to:

i. History;

ii. Review of systems;

iii. Comprehensive physical examination;

iv. Risk assessment;

v. Patient counseling;

vi. Routine laboratory tests;

vii. Development of the plan of care; and

viii. Special tests and/or procedures as medically indicated.

3. Subsequent prenatal visit content shall include, but not be limited to:

i. Review and revision of the patient plan of care;

ii. Interim history;

iii. Physical examination;

iv. Patient counseling and treatment;

v. Laboratory tests;

vi. Special tests and/or procedures which are medically indicated;

vii. Identification of new or developing problems; and

viii. Management, including transfers, of any new or persistent problems.

4. Transfer of prenatal records to the hospital of delivery shall occur no later than 34 weeks gestation.

(c) Obstetrical delivery services shall include, but not be limited to:

1. Determination of, and arrangements for, delivery site;

2. Attendance at or provision for obstetrical delivery by a qualified physician or certified nurse midwife; and

3. Medical care during the entire period of confinement.

(d) A postpartum visit shall be provided by the 60th day after delivery, and shall include, but shall not be limited to, the following:

1. History;

2. Review of the prenatal, labor and delivery record;

3. Physical examination;

4. Patient counseling and treatment;

5. Parent/infant assessment;

6. Referral/consultation, as indicated; and

7. Procedures/tests, as indicated.

(e) All HealthStart maternity care providers shall have policies and protocols which shall be consistent with national standards regarding consultation and transfer of medically high-risk patients to tertiary-level maternity care facilities or specialists and to genetic counseling and testing facilities.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), inserted a comma following "intrapartum", and substituted "Health's" for "Health and Senior Services' ".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.9

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.9 Health support services

(a) Case coordination services shall facilitate the delivery of continuous, coordinated, and comprehensive services for each patient in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:

1. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit.

2. Prenatal case coordination activities shall include, but shall not be limited to:

i. Orienting the patient to all services;

ii. Developing, maintaining and coordinating the plan of care in consultation with the patient;

iii. Coordinating and monitoring the delivery of all services and referrals;

iv. Monitoring and facilitating the patient entry into and continuation with maternity services;

v. Facilitating and providing advocacy for obtaining referral services;

vi. Reinforcing health teachings and providing support;

vii. Providing vigorous follow-up for missed appointments and referrals;

viii. Arranging home visits;

ix. Meeting with the patient and coordinating patient care conferences; and

x. Reviewing, monitoring and updating the patient's complete record.

3. Postpartum case coordination activities shall include, but shall not be limited to, the following:

i. Arranging and coordinating the postpartum visit and any home visit;

ii. Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;

iii. Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children Program (WIC), pediatric care, future family planning, Special Child Health Services, the County-Based Special Child Health and Early Intervention Services Case Management Units, early intervention services for infants with disabilities and other health and social agencies, if needed;

iv. Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;

v. Coordinating referrals and following up on missed appointments and referrals; and

vi. Reinforcing health instruction for mother and baby.

(b) Nutrition assessment and basic guidance services shall be provided to orient and educate the beneficiary about nutritional needs during pregnancy and to educate the beneficiary about good dietary practices in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines." Specialized nutrition assessment and counseling shall be provided to women with additional needs. Services shall be provided as follows:

1. Initial assessment services, which shall include, but shall not be limited to, the following:

i. Review of the patient's chart;

ii. Identification of dental problems which may interfere with nutrition;

iii. Nutrition history;

iv. Current nutritional status;

v. Determination of participation in WIC or other food supplement programs; and

vi. Identification of need for specialized nutrition counseling;

2. Subsequent nutrition assessment, which shall include, but shall not be limited to, the following:

i. Monitoring of weight gain/loss;

ii. Identification of special dietary needs; and

iii. Identification of need for specialized nutrition counseling services;

3. Prenatal nutrition guidance, which shall include, but shall not be limited to, the following:

i. Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;

ii. Review and reinforcement of other nutrition and dietary counseling services the patient may be receiving;

iii. Instruction on food purchase, storage and preparation;

iv. Instruction on food substitutions, as indicated;

v. Discussion of infant feeding and nutritional needs; and

vi. Referral to food supplementation programs through the case coordinator;

4. Specialized nutrition assessment and counseling, which shall be provided to those women with additional needs;

5. Referral for extensive specialized nutrition services, which shall be initiated by the medical care provider or the nutritionist under the supervision of the medical care provider in coordination with the case coordinator; and

6. Postpartum nutrition assessment and basic guidance services, which shall include, but shall not be limited to:

i. Review and reinforcement of good dietary practices;

ii. Review of instruction on dietary requirement changes; and

iii. Instruction on breast feeding and/or formula preparation and feeding.

(c) Social-psychological assessment and basic guidance services shall be provided to the beneficiary to assist the beneficiary in resolving social-psychological needs in accordance with the "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:

1. Initial social-psychological assessment services, which shall include, but shall not be limited to, the following:

i. Determining financial resources and living conditions;

ii. Determining the patient's personal support system;

iii. Determining the patient's attitudes and concerns regarding the pregnancy;

iv. Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;

v. Ascertaining educational and/or employment status and needs; and

vi. Identification of the need for specialized social-psychological and mental health evaluation and counseling services;

2. Subsequent social-psychological assessment services, which shall include, but shall not be limited to, the following:

i. Determining the patient's reaction to pregnancy;

ii. Ascertaining the reaction of family, friends and the actual support person to the pregnancy;

iii. Identifying the need for social service interventions and advocacy; and

iv. Identifying the need for specialized social-psychological and/or mental health evaluation and counseling;

3. Basic social-psychological guidance, which shall include, but not be limited to, the following:

i. Orientation and information on available community resources;

ii. Orientation regarding stress and stress reduction during pregnancy; and

iii. Assistance with arrangements for transportation, child care and financial needs;

4. Specialized, short-term social-psychological counseling, which shall be provided to women who are identified through assessment or basic counseling as having a need for more intense service;

5. Referral for extensive specialized social-psychological services, which shall be initiated by the medical care provider or by the social worker under the supervision of the medical care provider and in coordination with the case coordinator; and

6. Postpartum social-psychological assessment and guidance, which shall include, but shall not be limited to, the following:

i. Review of prenatal, labor, delivery and postpartum course;

ii. Assessment of the patient's current social-psychological status, including mother and infant bonding and the acceptance of the infant by the father and the family, as applicable;

iii. Identification of the need for additional social-psychological services;

iv. Review of available community resources for mother and infant, as applicable;

v. Counseling regarding fetal loss or infant death, if applicable; and

vi. Counseling regarding school/employment planning.

(d) Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines." Services shall be provided as follows:

1. Initial assessment of health educational needs, which shall include, but shall not be limited to, the patient's:

i. Educational background;

ii. Health education needs; and

iii. Previous education and experience concerning pregnancy, birth and infant care;

2. Health education instruction, which shall be provided for all patients based on their identified health education needs shall include, at a minimum, the following:

i. Normal course of pregnancy;

ii. Fetal growth and development;

iii. Warning signs, such as signs of pre-term labor, and identification of emergency situations;

iv. Personal hygiene;

v. Exercise and activity;

vi. Childbirth preparation, including management of labor and delivery;

vii. Preparation for hospital admission;

viii. Substance, occupational and environmental hazards;

ix. Need for continuing medical and dental care;

x. Future family planning;

xi. Parenting, basic infant care and development;

xii. Availability of pediatric and family medical care in the community; and

xiii. Normal postpartum physical and emotional changes.

3. Health education services, which shall include guidance in decision making and in the implementation of decisions concerning pregnancy, birth and infant care; and

4. Postpartum assessment of health education needs shall be conducted.

(e) One face-to-face preventive health care contact shall be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:

1. This contact shall include, but shall not be limited to:

i. Review of the mother's health status;

ii. Review of the infant's health status;

iii. Review of mother/infant interaction;

iv. Revision of the plan of care; and

v. Provision of additional services, as indicated; and

2. The provider shall provide or arrange for one or more home visits for each high-risk patient in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(f) HealthStart maternity care providers shall utilize existing community services to enhance the maternity care services.

(g) HealthStart maternity care providers shall have written procedures, which identify specific agencies or practitioners and criteria for referral of patients requiring services which are extensive, complex, or expected to extend beyond the pregnancy. These procedures shall include, but shall not be limited to: nutrition and food supplementation services, substance use disorder treatment facilities, mental health services, county/local social and welfare agencies, parenting and child care educational programs, future family planning services, fetal alcohol syndrome, and AIDS counseling services.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Substituted "Health's" for "Health and Senior Services' " throughout; in the introductory paragraph of (a), inserted a comma following "coordinated"; and in (g), inserted a comma following the first occurrence of "procedures", following "complex", and following "syndrome", and substituted "use disorder" for "abuse".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.10

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.10 Professional staff requirements for HealthStart Comprehensive Maternity Care services

(a) All HealthStart comprehensive maternity care services shall be delivered through a team approach by qualified professionals.

(b) Physicians and certified nurse midwives shall be Medicaid/NJ FamilyCare fee-for-service providers and have obstetrical admitting privileges at a licensed maternity care facility.

(c) Case coordinators shall have, at a minimum, a license as a registered nurse; or a Bachelor's degree in social work, health or a behavioral science.

(d) Health professionals shall have a valid license to practice their professions, as required by the State of New Jersey.

(e) All other professionals, for whom no license to practice is required, shall meet generally accepted professional standards for qualification.

(f) Paraprofessionals shall be familiar with the local community, have knowledge or skills in maternal and child health services and shall be supervised by a health professional.

(g) Prenatal, delivery, and postpartum medical services shall be delivered by a physician or a certified nurse midwife.

(h) Nutrition, social-psychological and health education assessments and development of the plan of care shall be provided by appropriate professionals in each of the specialty areas, or by case coordinators or medical care professionals. If the nutrition or social-psychological assessment portion of the plan of care is provided by a case coordinator or medical care professional, then these portions shall be reviewed by a nutritionist or social worker, respectively.

(i) Nutrition and social-psychological basic counseling shall be provided by a case coordinator with at least one year of experience in providing services to maternity patients or by the appropriate specialist in each of the areas or by a registered nurse or obstetrical care provider.

(j) Short term specialized social-psychological and nutrition counseling services shall be provided by a social worker and nutritionist, respectively. The social worker and nutritionist shall be available on site during patient visits.

(k) There shall be adequate professional, paraprofessional and clerical staff to provide, in a timely manner, maternity care services as described herein which meet the needs of the patients.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), inserted a reference to NJ KidCare--Plan A fee-for-service providers.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (b), substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.11

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.11 Records; documentation, confidentiality, and informed consent requirements for HealthStart maternity care providers

(a) HealthStart maternity care providers shall have policies which protect patient confidentiality, provide for informed consent and document prenatal, labor, delivery, and postpartum services in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(b) An individual record shall be maintained for each patient throughout the pregnancy.

(c) Each record shall be confidential and shall include at least the following: history and physical examination findings assessment, a plan of care, treatment services, laboratory reports, counseling and health instructions provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart services.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

Rewrote (a); in (c), substituted "plan of care' for "Care Plan".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Records; documentation, confidentiality and informed consent requirements for HealthStart maternity care providers". In (a), inserted a comma following "delivery", and substituted "Health's" for "Health and Senior Services' ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-3.12

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.12 Standards for HealthStart pediatric care

(a) Pediatric care services shall be comprehensive, integrated and coordinated.

(b) HealthStart pediatric care providers shall be Medicaid/NJ FamilyCare fee-for-service providers and shall:

1. Directly provide preventive child health care, maintenance of complete patient history, outreach for preventive care, initiation of referrals for appropriate medical, educational, social, psychological and nutrition services, and follow-up of referrals and sick care;

2. Directly provide or arrange for non emergency room-based, 24-hour physician telephone access for eligible patients; and

3. Directly provide or arrange for sick care and emergency care.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), inserted a reference to NJ KidCare--Plan A fee-for-service providers.

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

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

In (b), substituted "FamilyCare" for "KidCare-PlanA" preceding "fee-for-service" in the introductory paragraph, substituted "child health" for ", well-child" following "Directly provide preventive" in 1, and substituted "for eligible" for "to" following "telephone access" in 2.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (b), substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-3.13

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.13 Professional requirements for HealthStart pediatric care providers

All HealthStart pediatric care providers shall be pediatricians or have a physician on staff who possesses a knowledge of pediatrics. This may be demonstrated by eligibility for board certification by the American Academy of Pediatrics, the American Osteopathic Board of Pediatrics, or by hospital admitting privileges in pediatrics.

History

HISTORY:

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

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

Substituted "pediatricians" for "physicians" following "providers shall be" and substituted "American Academy of Pediatrics, the American Osteopathic Board of Pediatrics, or by hospital admitting privileges" for "American Academy of Pediatrics and/or by hospital admitting privileges" following "board certification by the".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-3.14

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.14 Preventive care services provided by HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall provide preventive health visits in accordance with the recommended guidelines of the American Academy of Pediatrics. The schedule shall include a two-to four-week visit, two-month visit, four-month visit, six-month visit, nine-month visit, 12-month visit, 15-month visit, 18-month visit and 23-to 24-month visit. Each visit shall include, at a minimum, medical, family and social history, unclothed physical examination, developmental and nutritional assessment, vision and hearing screening, dental assessment, assessment of behavior and social environment, anticipatory guidance, age appropriate laboratory examinations, and immunizations. Referrals shall be made as appropriate.

(b) Each provider shall provide or arrange for sick care and 24-hour telephone physician access during non-office hours. If not directly provided by the HealthStart provider, sick care and 24-hour telephone access shall be provided for each child by a single designated provider via a documented agreement. Information on care given shall be communicated to the primary HealthStart pediatric care provider. Telephone access provided exclusively via emergency room staff shall not be permitted. Referral to the emergency room should occur only for emergency medical care or urgent care.

(c) Case coordination outreach and follow-up services shall include letter or telephone call reminders to the child's parent or guardian for preventive well-child visits and letter or telephone follow-up of missed appointments. Referrals for home visit services for follow-up shall be made when appropriate. For all referrals and follow-up visits, the provider shall document the completion of such referrals or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and to the referred agency shall be sent or made, encouraging the follow through of the referral. All of the activity shall be recorded on the patient's chart.

(d) All HealthStart pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational, and nutrition services. This may include, but shall not be limited to: the Special Supplemental Food Program for Women, Infants and Children Program (WIC), the Division of Child Protection and Permanency, Special Child Health Services Case Management Units' Child Evaluation Centers, early intervention programs, county welfare agencies, certified home health agencies, community mental health centers, and local and county health departments.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (d), substituted a reference to County Boards for a reference to County Welfare Agencies/Boards.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (d), inserted a comma following "educational" and following "centers", and substituted "Child Protection and Permanency" for "Youth and Family Services", "Units' " for "Units and", and "welfare agencies" for "boards of social services".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-3.15

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.15 Records; documentation, confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall have policies which protect patient confidentiality, provide for informed consent and document comprehensive care services.

(b) An individual record shall be maintained for each patient.

(c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, plan of care, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart pediatric services.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Rewrote (a); in (c), substituted "plan of care" for "Care Plan".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-3.16

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.16 Reimbursement for HealthStart providers

(a) The HealthStart HCPCS procedure codes listed in this subchapter are governed by the same rules that appear in the HCPCS subchapter of each non-institutional provider services manual (Independent Clinic, Physician and the Nurse Midwifery Services Chapters). The maximum fee allowance schedule and reimbursement requirements for HCPCS HealthStart Maternity Codes (Medical Care and Health Support Services) and HCPCS HealthStart Pediatric Codes are listed under N.J.A.C. 10:66-6.

(b) A hospital outpatient department (OPD) which is a HealthStart Provider shall use the procedure for OPD billing (UB-92 claim form), contained in this chapter; except for the following services:

1. HealthStart Health Support Services (W9040 through W9043), which shall be billed on the CMS 1500 claim form, using the Independent Clinic billing number; and

2. HealthStart pediatric continuity of care services (W9070), which shall be billed on the MC-19 form, EPSDT Referral Report.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), substituted a reference to HCFA 1500 claim forms for a reference to 1500 N.J. claim forms in 1, and substituted a reference to EPSDT Referral Report for a reference to Report and Claim for EPSDT/Health--Start Screening and Related Procedures.

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

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

In (a), deleted "policies and" preceding "rules that appear" and amended the N.J.A.C. reference; in (b), rewrote the introductory paragraph and substituted "CMS" for "HCFA" preceding "1500 claim form" in 1.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-3.17

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 3. HEALTHSTART--MATERNITY AND PEDIATRIC CARE SERVICES

§ 10:52-3.17 HealthStart Maternity Care billing code requirements

(a) HealthStart Maternity Care billing code requirements shall be as follows:

1. Separate reimbursement shall be available for maternity medical care services and maternity health support services.

2. Maternity medical care services shall be billed as a total obstetrical package, when applicable, but may be billed as separate procedures.

3. The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart maternity medical or health support service.

4. The modifier "WM" in the HCPCS lists of codes (W9025 through W9030) refers to those services provided by certified nurse midwives who shall include the modifier at the end of each code. HCPCS codes for health support services do not require the "WM" modifier on HCPCS codes W9040 and W9043.

5. Laboratory and other diagnostic procedures and all necessary medical consultations shall be eligible for separate reimbursement.

(b) HealthStart maternity medical care procedure codes are provided in N.J.A.C. 10:66-6, the Healthcare Common Procedure Coding System (HCPCS) for Independent Clinic Services.

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

In (a), substituted "applicable" for "feasible" preceding ", but may be billed" in 2; rewrote (b).

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-4.1

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.1 Basis of payment; acute general hospitals reimbursed under the Diagnosis Related Groups (DRG) system--inpatient services

(a) For inpatient services with discharge dates prior to August 3, 2009, the Division will reimburse acute care general hospitals for inpatient services based upon rates determined under N.J.A.C. 10:52-5 through 7 and 9, except for distinct units of acute care general hospitals. For reimbursement methodology for distinct units of acute care general hospitals, see *N.J.A.C. 10:52-4.2(e)*.

(b) For inpatient services with discharge dates on or after August 3, 2009, the Division will reimburse acute care general hospitals for inpatient services based upon rates determined under N.J.A.C. 10:52-14. However, the reimbursement methodology for distinct units of acute care general hospitals is not changed on or after that date. See *N.J.A.C. 10:52-4.2(e)*.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Changed N.J.A.C. reference.

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

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

Amended the final N.J.A.C reference.

Amended by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Designated the existing text as (a); in (a), substituted "For inpatient services with discharge dates prior to August 3, 2009, the" for "The" and "7 and 9" for "8"; and added (b).

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-4.2

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.2 Basis of payment; special hospitals (Classification A and B), private and governmental psychiatric hospitals and distinct (excluded units) of acute general hospitals--inpatient services

(a) The Division will reimburse special hospitals (Classification A) (acute and short term special hospitals) and Classification B (Rehabilitation hospitals), excluding specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services, effective for the 2002 rate year, in accordance with P.L. 2001, c.393, section 5, for inpatient services (including the interim and final settlement), in accordance with Medicare principles of reimbursement (see 42 CFR 413).

(b) Specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services will be reimbursed a prospective per diem rate. The initial prospective per diem rate, effective for the 2002 rate year, shall be based on the total Medicaid inpatient costs divided by the total Medicaid days for Fiscal Year 1999, using the hospital's first finalized audited Fiscal Year 1999 cost report. If the hospital has been in operation less than two full years prior to Fiscal Year 1999, the prospective per diem rate shall be set using the hospital's first finalized audited Fiscal Year 2000 cost report. The initial prospective rate shall be increased annually by an economic factor, as specified in *N.J.A.C. 10:52-5.13(a)*.

1. A hospital may request a change to its prospective per diem rate as either an adjustment to its base year costs in accordance with *42 CFR 413.40(g)*, or assignment of a new base year in accordance with *42 CFR 413.40(i)*.

2. The hospital's request shall be received within 180 days from the end of the fiscal year for which the adjustment or new base was requested, and shall include all supporting documentation.

3. The Division may grant an interim adjustment, subject to final adjudication of the hospital's request. The Division's final determination shall be made based upon financial data from the hospital's audited cost report for the year for which the adjustment or new base year was requested.

4. The Division shall issue a written determination with an explanation for each request for an adjustment or new base year.

5. If a hospital is not satisfied with the Division's determination, the hospital may request an administrative hearing pursuant to N.J.A.C. 10:49-10. If the hospital elects to request an administrative hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision, adopting, modifying or rejecting the Administrative Law Judge's initial decision. Thereafter, review may be sought in the Appellate Division.

(c) Prior authorization shall be required for patients with prognoses that necessitate lengths of stay in excess of 30 days. Reimbursable patient days shall be subject to utilization review requirements as specified in *N.J.A.C. 10:52-1.15*.

(d) The Medicaid/NJ FamilyCare program will reimburse special hospitals (Classification C) according to the rules and reimbursement methodology of *N.J.A.C. 8:85*, Long Term Care Services.

(e) The Division will reimburse private psychiatric hospitals and distinct units of acute general hospitals for inpatient services (including the interim and final settlement) in accordance with Medicare principles of reimbursement. Distinct units of acute general hospitals are not reimbursed through the Diagnosis Related Groups (DRG) reimbursement system for inpatient services in acute care general hospitals.

(f) Therapeutic leave days (days spent outside the facility) are not reimbursed to hospitals by the Division.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), substituted a reference to the Medicaid and NJ KidCare program for a reference to the Division; and in (c), deleted N.J.A.C. reference.

Amended by R.2002 d.376, effective November 18, 2002.

See: *34 N.J.R. 2247(a)*, *34 N.J.R. 2549(b)*, *34 N.J.R. 3980(b)*.

Rewrote the section.

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

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

In (a), substituted "2001" for "2002" preceding ", c.393"; in (d), substituted "FamilyCare" for "KidCare" preceding "program" and amended the N.J.A.C. reference.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (d), substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-4.3

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care hospitals-outpatient services

(a) The Division shall reimburse general hospitals, special hospitals (Classification A), rehabilitation hospitals (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care hospitals for covered outpatient hospital services provided in outpatient hospital departments approved by the Division as meeting the criteria for participation, in accordance with *N.J.A.C. 10:52-1.3(b)* and consistent with the following conditions and reimbursement methodology:

1. Establishment of a final rate of reimbursement: The final rate of reimbursement is based on the lower of cost or charges as defined by Medicare principles of reimbursement at *42 CFR 413.1*; and

2. Establishment of an interim rate of reimbursement: The charge for an outpatient service is subject to a reduction based on the application of a cost-to-charge ratio determined for each individual hospital by the Division, in accordance with Medicare principles of reimbursement at *42 CFR 413.1*. This cost-to-charge ratio is used to assure that reimbursement for outpatient services does not exceed the rate based on Medicare principles of reimbursement.

i. Hospitals shall notify the Division of any changes made to the hospital's charge structure or cost-to-charge ratios. Notice shall be given 30 days prior to implementation of the change, in writing, addressed to:

Office of Hospital Reimbursement

Division of Medical Assistance and Health Services

PO Box 712 Mail Code #44

Trenton, NJ 08625-0712

3. Effective for services rendered on or after July 1, 1991 through October 6, 1996, the Division is reducing the interim reimbursement rates for covered outpatient services subject to the cost-to-charge ratio in general, special (Classification A), rehabilitation (Classification B) private and governmental psychiatric hospitals, and distinct units of acute care hospitals by 4.4 percent. The final settlement for covered outpatient services subject to the cost-to-charge ratio is the lower of costs or charges minus 4.4 percent. Effective for services rendered on and after October 7, 1996 and including the fiscal year ending June 30, 2001, the Division shall reduce hospital outpatient capital cost by 10 percent and reasonable cost of hospital outpatient services (net of the outpatient capital cost) by 5.8 percent as reported in the Medicare Cost Report (CMS-2552). This reduction shall be calculated when the Medicare Cost Report (CMS-2552) is finalized and if the report is amended. Effective for fiscal years ending on or after July 1, 2001, the Division shall reduce hospital outpatient capital cost by 10 percent and the reasonable cost of hospital outpatient services (net of the outpatient capital cost) by 5.8 percent. The 5.8 percent reduction will be calculated during the interim and final settlement process of

the Medicare cost report (CMS-2552) and if the report is amended. The 10 percent outpatient capital cost reduction will be calculated at final settlement and if the cost report is amended. The reduction shall apply to general, special (Classification A), rehabilitation (Class-ification B) and private and governmental psychiatric hospitals, and distinct units of acute care hospitals.

(b) Certain outpatient services, that is, most laboratory services, all renal dialysis services, all dental services, some HealthStart services, Medicare deductible and coinsurance amounts, and all outpatient psychiatric services are excluded from a reduction based on the cost-to-charge reimbursement methodology and have their own reimbursement methodology as follows:

1. Most outpatient laboratory services are reimbursed on the basis of a fee-for-service schedule using the Healthcare Common Procedure Coding System (HCPCS) procedure codes and the fee schedule contained in N.J.A.C. 10:52-10. If the hospital charge is less than the amount on the fee allowance, reimbursement is based upon the actual billed charge. In addition, there are situations which have unique billing arrangements, as follows:

i. Specimen collection, that is, a routine venipuncture for collection of specimen(s) or a catheterization for collection of urine specimen(s) shall be reimbursed at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day. (See HCPCS GOOO1 and P9615 in *N.J.A.C. 10:52-10.3*); and

ii. Profiles and panels shall be reimbursed as follows:

(1) Profiles are comprised of those components of a test or series of tests performed as groups or combinations (profiles) which are performed on automated multichannel equipment and are finished identifiable laboratory study(ies). Examples are: The components of an SMA (Sequential Multichannel Automated Analysis) 12/60 or other automated laboratory study. Complete blood counts (CBC) with inclusion of Hemoglobin, Hematocrit, Red Blood Cell (RBC) Counts, Red Blood Cell (RBC) indices, White Blood Cell (WBC) Counts, and Differentials, MCHs, MCVs and MCHCs, are calculations and not billable services. If the components of a profile or panel are billed separately, reimbursement for the components of the profile shall not exceed the Medicaid/NJ FamilyCare fee schedule for the profile itself.

(2) Panels are laboratory tests that are associated with other organ or disease oriented areas, such as organ "panels". Examples are hepatic function panels and lipid panels. The tests listed with each panel identifies the defined components of that panel. (See also (b)2iii below.)

2. Some outpatient laboratory services which use laboratory HCPCS procedure codes that are reimbursed based on actual billed charges, are subject to the cost-to-charge ratio. These include procedure codes such as:

i. Those valid for Medicaid NJ FamilyCare fee-for-service reimbursement but not listed on the Medicare Laboratory HCPCS Procedure Code File (see *42 U.S.C. § 1395L*). They are designated as "subject to cost-to-charge" or S.C.C. in *N.J.A.C. 10:52-10.1*;

ii. For those HCPCS codes submitted for payment on the same claim with charges for blood products (if no blood product is provided and/or billed on the same claim, the codes are reimbursed according to the fee allowance schedule); and

iii. For some codes associated with other laboratory services such as for organ or disease oriented panels; clinical pathology consultations; unlisted chemistry or toxicology procedures; certain bone marrow testing; certain specific or unlisted hematology procedures; certain immunology testing; unlisted microbiology procedures; and certain procedures under anatomic pathology.

3. All renal dialysis services for end-stage renal disease (ESRD) shall be reimbursed at 100 percent of the base composite rate and shall include any add-on charge to the base composite rate approved by Medicare.

i. Renal dialysis services provided on an emergency basis in a hospital center not approved to provide renal dialysis services for ESRD are reimbursed actual billed charges, subject to the cost-to-charge ratio.

4. All dental services are reimbursed in accordance with the Division Dental Fee Schedule. This fee-for-service schedule is consistent with the Division's fees paid to the private practitioners and independent dental clinics. For information about dental services in the Outpatient Department, see *N.J.A.C. 10:52-2.3*.

5. All HealthStart maternity health support services and pediatric continuity of care services shall be reimbursed on a fee-for-service basis in the hospital outpatient department. All other HealthStart maternity and pediatric care services shall be reimbursed based on the cost-to-charge ratio. See *N.J.A.C. 10:52-3.16*.

6. Early Periodic Screening, Diagnosis, and Treatment services are reimbursed in the hospital outpatient department according to the specific reimbursement methodology. (See also *N.J.A.C. 10:52-2.4*.)

i. The physician who is allowed by the hospital to bill Medicaid or NJ FamilyCare fee-for-service separately from the hospital costs (unbundled) for EPSDT services, shall bill on the EPSDT form.

7. All deductible and coinsurance amounts for Medicare crossover claims shall not be subject to the cost-to-charge ratio and are reimbursed at 100 percent of the amounts.

8. All outpatient psychiatric services provided to individuals 21 years of age and over shall be paid fee-for-service for the following service categories at the lower of charges or prospective unit rates.

i. Separate unit rates shall be reimbursed for the following service categories as defined in *N.J.A.C. 10:52* and 10:52A:

(1) Adult acute partial hospital services shall be billed on an hourly basis using revenue code 913. At least two hours per day of services shall be billed, but not more than five hours. The hourly unit rate is $ 65.00. When revenue code 913 is billed, no other outpatient psychiatric revenue code can be billed on the same date of service.

(2) Partial hospital services shall be billed on an hourly basis using revenue code 912. At least two hours per day shall be billed, but not more than five hours. The hourly unit rate is $ 33.08. When revenue code 912 is billed, no other outpatient psychiatric revenue code can be billed on the same date of service.

(3) Individual outpatient hospital psychiatric services shall be billed on a unit basis of 30 minutes using revenue code 914. The daily billing limit is two units per day. The half hour unit rate is $ 50.00.

(4) Initial evaluations shall be billed on a unit basis of 30 minutes using revenue code 918. The daily billing limit is four units per day. The half hour unit rate is $ 62.50.

(5) Group outpatient hospital psychiatric services shall be billed on an hourly basis using revenue code 915. The billing limit is three hours per week. The hourly unit rate is $ 30.00.

(6) Medication monitoring and medication management shall be billed on a unit basis of 15 minutes using revenue code 919. The daily billing limit shall be two units per day. The 15 minutes unit rate is $ 42.00.

ii. Costs related to all outpatient psychiatric services for individuals 21 years of age and over shall be excluded from outpatient cost settlements. Hospitals shall maintain a separate cost center on the Medicare cost report for all outpatient psychiatric services, regardless of the age of the individuals treated. Hospitals shall report all psychiatric outpatient costs, charges, and statistics in this separate cost center.

9. All outpatient psychiatric services provided to youth and young adults under age 21 shall be paid fee-for-service for the following service categories at the lower of charges or prospective unit rates:

i. Separate unit rates shall be reimbursed for the following service categories as defined in *N.J.A.C. 10:52* and 10:52A:

(1) Youth and young adult partial hospital services shall be billed on an hourly basis using revenue code 913. The rate is $ 73.00 per hour. A claim for such services shall not be billed or reimbursed for any day on which less than two hours of such services are provided to the beneficiary. A claim shall not be billed or reimbursed for more than five hours of such services per day provided to the beneficiary. When revenue code 913 is billed, no other outpatient psychiatric revenue code can be billed for the same day of service.

(2) Individual outpatient hospital psychiatric services for youth or young adults shall be billed on a unit basis of 30 minutes using revenue code 914. The daily billing limit is three units per day, to include family conferencing, which can be up to 1.5 hours per day. The half hour rate is $ 50.00. Individual sessions where the youth is the sole participant should not exceed two units per days, unless there are extenuating circumstances that shall be documented in the file prior to the submission of the claim for reimbursement.

(3) Evaluations for youth and young adults shall be billed on a unit basis of 30 minutes using revenue code 918. The daily billing unit is four units per day. The half hour unit rate is $ 62.50. Reimbursement is available if the evaluation is performed by a clinically licensed mental health professional and can include specialized assessments, as well as evaluations for admission into a partial hospital program for youth or young adults.

(4) Group outpatient hospital psychiatric services for youth or young adults shall be billed on an hourly basis using revenue code 915. The billing limit is three hours per week. The hourly unit rate is $ 30.00.

(5) Medication management for youth or young adults shall be billed on a unit basis of 15 minutes using revenue code 919. The daily billing limit shall be two units per day. The 15-minute unit rate is $ 42.00.

ii. Costs related to all outpatient psychiatric services for youth and young adults under the age of 21 shall be excluded from outpatient cost settlements. Hospitals shall maintain a separate cost center on the Medicare cost report for all outpatient psychiatric services, regardless of the age of the individuals treated. Hospitals shall report all psychiatric outpatient costs, charges, and statistics in this separate cost center.

(c) Emergency room visits for treatment of conditions that are not the responsibility of an MCO or for Medicaid/NJ FamilyCare fee-for-service beneficiaries who are not admitted as inpatients shall be coded by the hospital as requiring primary care or non-primary care.

1. Primary care is defined as those categories described in the Physicians' Current Procedural Terminology (CPT) as either minimal, brief, or limited service.

2. Non-primary care shall be defined as those categories described in the Physicians' Current Procedural Terminology (CPT), 1994, as amended and supplemented, as either intermediate, extended, or comprehensive service.

3. Hospitals shall not refuse to provide emergency room services to any Medicaid/NJ FamilyCare beneficiary for the reason that such beneficiary does not require services on an emergency basis.

4. The cost of emergency room services for a Medicaid/NJ FamilyCare fee-for-service beneficiary for the treatment of a condition that is not the responsibility of an MCO when the beneficiary is admitted as an inpatient shall be allocated to the inpatient rates and shall not be reimbursed through the outpatient hospital's reimbursement methodology, as stated above.

History

HISTORY:

Amended by R.1996 d.479, effective October 7, 1996.

See: *28 N.J.R. 3221(b)*, *28 N.J.R. 4479(b)*.

Amended by R.1997 d.396, effective September 15, 1997.

See: *29 N.J.R. 1003(a)*, *29 N.J.R. 4132(b)*.

Rewrote (a).

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted references to governmental psychiatric hospitals for references to psychiatric hospitals and inserted references to distinct units of acute care hospitals throughout, and changed N.J.A.C. reference in the introductory paragraph; in (b)1, substituted a reference to fee-for-service schedules for a reference to fee-for-service in the introductory paragraph, changed N.J.A.C. reference in i, and substituted a reference to Medicaid NJ KidCare for a reference to Medicaid in ii(1); in (b)2i, substituted a reference to Medicaid NJ KidCare fee-for-service reimbursement for a reference to Medicaid reimbursement, and changed N.J.A.C. reference; in (b)6i, inserted a reference to NJ KidCare fee-for-service; and rewrote (c).

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

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

Rewrote the section.

Amended by R.2007 d.59, effective February 5, 2007.

See: *38 N.J.R. 4359(a)*, *39 N.J.R. 456(a)*.

In the introductory paragraph of (b), deleted "and the" preceding "Medicare" and substituted "and all outpatient psychiatric services for individuals 22 years of age and over" for a comma following "amounts"; and added (b)8.

Amended by R.2008 d.375, effective December 15, 2008.

See: *40 N.J.R. 4667(a)*, *40 N.J.R. 6966(b)*.

In the introductory paragraph of (b), deleted "for individuals 22 years of age and over" preceding "are excluded"; in (b)8, substituted "21" for "22"; and added (b)9.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In the introductory paragraph of (b)3, inserted "base" twice.

Amended by R.2012 d.050, effective March 5, 2012.

See: *43 N.J.R. 2112(a)*, *44 N.J.R. 594(a)*.

Section was "Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care hospitals--outpatient services". In (b)8i(2), substituted "$ 33.08" for "$ 35.00".

Amended by R.2014 d.118, effective July 21, 2014.

See: *46 N.J.R. 419(a)*, *46 N.J.R. 1693(a)*.

Section was "Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals and distinct units of acute care hospitals-outpatient services". In the introductory paragraph of (b), inserted a comma following "amounts"; in the introductory paragraph of (b)8, inserted "fee-for-service for the following service categories"; in (b)8i(3), substituted "$ 50.00" for "$ 40.00"; in (b)8i(4), substituted "$ 62.50" for "$ 50.00"; in (b)8i(6), substituted "$ 42.00" for "$ 34.00"; in (b)8ii, substituted "21" for "22", and inserted a comma following "charges"; added new (b)9i; recodified former (b)9i through (b)9v as (b)9i(1) through (b)9i(5), and added (b)9ii.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (b)1, deleted "the" preceding "N.J.A.C."; in (b)1ii(1), the introductory paragraph of (c), and (c)3, made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare; and in the introductory paragraph of (c) and (c)4, substituted "MCO" for "HMO".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-4.4

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.4 Basis of payment; hospital capital project adjustment

(a) Any qualifying hospital that has completed a capital facilities construction project with an approved certificate of need from the New Jersey Department of Health, which meet both conditions in (a)1 below will be eligible for increased payments for capital project funding related to its Medicaid/NJ FamilyCare-Plan A managed care utilization.

1. The conditions required in (a) above are:

i. The approval is for a single capital project in excess of $ 20 million, which is for replacement beds, which reduce the number of hospital beds available in the State as of September 15, 1997; and

ii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low income revenue percentage shall be based on the sum of the Medicaid revenue as reported on Forms E-5 and E-6, line 1, column E, plus the Charity Care revenue as reported on Forms E-5 and E-6, line 1, column J, divided by the sum of the total revenue as reported on Forms E-5 and E-6, line 1, column M.

2. Payments to eligible hospitals shall begin upon project completion and facility operation.

3. The hospital-specific capital project funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid/NJ FamilyCare -Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

History

HISTORY:

New Rule, R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Former *N.J.A.C. 10:52-4.4*, Basis of payment and appeal procedure; out-of-State hospital services, recodified to *N.J.A.C. 10:52-4.5*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a), deleted "and Senior Services" following "Health"; and in the introductory paragraph of (a) and (a)3, substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-4.5

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.5 Basis of payment and appeal procedure; out-of-State acute care general hospital services

(a) The Division shall reimburse an out-of-State approved acute care general hospital (see *N.J.A.C. 10:52-1.2*, Definitions) for providing inpatient and outpatient hospital services to New Jersey Medicaid/NJ FamilyCare beneficiaries if the hospital meets the requirements of the Division and the services are prior authorized pursuant to *N.J.A.C. 10:52-1.10*. Reimbursement of inpatient hospital services is outlined in (b) and (c) below, and for outpatient services is outlined in (d) and (e) below. See (f) below for the procedure for rate appeals for out-of-State acute care general hospitals.

(b) Reimbursement for inpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid/NJ FamilyCare program and participating in the Medicaid program in the state in which the hospital is located, shall be based on the following criteria:

1. All rates in effect at the time the service is rendered shall be considered final rates by the State. Reimbursement shall be at the lesser of the established DRG payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-14 (excluding add-ons), 100 percent of the claim-specific reimbursement methodology approved by the state Medicaid agency in the state in which the hospital is located, except as specified in (b)2 and (c) below, or the total charges reflected on the claim. The Division shall not reimburse out-of-State acute care general hospitals for disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the state Medicaid agency in the state in which the hospital is located.

2. An out-of-State acute care general hospital should provide official documentation of the Medicaid rate that has been established by the state Medicaid agency in the state in which the hospital is located. If official documentation is not provided upon request by the Division, the claim will be denied.

i. An example of acceptable documentation is a copy of the letter sent by the state Medicaid agency to the hospital specifying the Medicaid rate.

(c) In the event an out-of-State acute care general hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with the state Medicaid agency:

1. Reimbursement for inpatient services shall be at the lesser of the established DRG payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-14 (excluding add-ons), a rate negotiated with the Division at the time of enrollment for inpatient hospital services, or the total charges reflected on the claim.

2. Reimbursement for out-of-State inpatient hospital services for organ transplantation and procurement provided to a Medicaid/NJ FamilyCare beneficiary who has been determined to be in need of, and approved for, a kidney, heart, heart-lung, liver, bone marrow transplant, or other selected medically necessary organ transplants, except for those transplants categorized as experimental because of a life threatening situation, shall be at a rate negotiated between the New Jersey Medicaid/NJ FamilyCare program and the hospital performing the organ transplant.

3. Cornea transplants, although not life-threatening, shall be reimbursed as any other out-of-State transplant service.

(d) Reimbursement for outpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid/NJ FamilyCare program and participating in the Medicaid program in the state in which the hospital is located shall be based on the following criteria:

1. All rates in effect at the time the service is rendered shall be considered final rates by the State. Reimbursement shall be at the lesser of the New Jersey Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care general hospitals, as described in *N.J.A.C. 10:52-4.3*; 100 percent of the claim-specific reimbursement methodology approved by the state Medicaid agency in the state in which the hospital is located, except as specified in (d)2 and (e) below; or the total charges reflected on the claim.

i. The New Jersey Statewide average cost-to-charge ratio is the average cost-to-charge ratio of all New Jersey acute care general hospitals based on the prior calendar year's hospital specific cost-to-charge ratio. This information is updated annually and published on the fiscal agent's website.

2. An out-of-State acute care general hospital should provide official documentation of the Medicaid rate that has been established by the state Medicaid agency in the state in which the hospital is located. If official documentation is not provided upon request by the Division, the claim will be denied.

i. An example of acceptable documentation is a copy of the letter sent by the state Medicaid agency to the hospital specifying the Medicaid rate.

(e) In the event that an out-of-State acute care general hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with that state's Medicaid agency, reimbursement for outpatient services shall be at the lesser of the New Jersey Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care general hospitals, as described in *N.J.A.C. 10:52-4.3*, or the total charges reflected on the claim.

(f) In addition to the provisions of *N.J.A.C. 10:52-9.1(c)* and (d), the following rate appeal procedure shall be followed for a rate appeal filed by an out-of-State hospital:

1. If an out-of-State hospital wishes to file an appeal concerning issues related to the rate of reimbursement, the appeal shall be filed by the hospital, in writing, to the following address within 20 calendar days after the filing of a rate appeal by the hospital to the State Medicaid agency in the state in which the hospital is located.

Division of Medical Assistance and Health Services

Office of Administrative and Financial Services

PO Box 712, Mail Code #44

Trenton, New Jersey 08625-0712

2. The following limitations shall apply to the rate appeal procedure in (f)1 above.

i. The hospital shall submit with its rate appeal to the Division all appropriate documentation demonstrating that an appeal was filed with the state Medicaid agency in the state in which the hospital is located and the date that the appeal was filed.

ii. If the hospital did not file a timely appeal in the state in which it is located, the payment made by the New Jersey Medicaid or NJ FamilyCare program shall be considered the final payment.

History

HISTORY:

Amended by R.1998 d.352, effective July 20, 1998.

See: *30 N.J.R. 1258(a)*, *30 N.J.R. 2653(a)*.

In (a), substituted "NJ KidCare beneficiaries" for "recipients", changed N.J.A.C. references, and added a new last sentence; rewrote (b); and added a new (e).

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a) and (e), changed N.J.A.C. references; and in (c), substituted a reference to Medicaid and NJ KidCare beneficiaries for a reference to Medicaid recipients and substituted a reference to the Medicaid/NJ KidCare program for a reference to the Medicaid program in 1.

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

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

In (a), amended the N.J.A.C. reference; in (c), designated the former last sentence of 1 as 2; substituted "FamilyCare" for "KidCare" throughout.

Recodified from *N.J.A.C. 10:52-4.4* by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Former *N.J.A.C. 10:52-4.5*, Reimbursement for third-party claims, recodified to *N.J.A.C. 10:52-4.6*.

Amended by R.2014 d.034, effective February 18, 2014 (operative July 1, 2014).

See: *45 N.J.R. 243(a)*, *45 N.J.R. 624(a)*, *46 N.J.R. 356(c)*.

Section was "Basis of payment and appeal procedure; out-of-State hospital services". Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), the introductory paragraph of (b) and of (d), and (c)2, substituted "Medicaid/NJ" for "Medicaid or NJ" throughout.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-4.6

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.6 Reimbursement for claims for which there is third-party liability

(a) For beneficiaries for whom any third-party liability exists, claims for hospital services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with *N.J.A.C. 10:49-7.3* and the provisions of this chapter.

(b) For beneficiaries eligible for Medicare and Medicaid (dual eligibles), claims covered under *N.J.A.C. 10:52-4.7* shall be reimbursed in accordance with the provisions of that section.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote the section.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

Recodified from *N.J.A.C. 10:52-4.5* by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Former *N.J.A.C. 10:52-4.6*, Medicare/Medicaid or Medicare/NJ FamilyCare claims, recodified to *N.J.A.C. 10:52-4.7*.

Repeal and New Rule, R.2014 d.030, effective February 3, 2014.

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

Section was "Reimbursement for third-party claims".

Annotations

Notes

§ 10:52-4.6 Reimbursement for claims for which there is third-party liability

Chapter Notes

End of Document

N.J.A.C. 10:52-4.7

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.7 Medicare/Medicaid or Medicare/NJ FamilyCare claims

(a) Some patients may be covered under both Medicare and Medicaid or Medicare and NJ FamilyCare. When the Medicaid/NJ FamilyCare beneficiary is covered under both programs, Item 57 on the hospital claim form shall be completed showing the Medicaid/NJ FamilyCare Eligibility Identification Number.

(b) Medicare/Medicaid and Medicare/NJ FamilyCare third-party claims for hospital services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with *N.J.A.C. 10:49-7.3* and the provisions of this chapter.

(c) When Medicaid/NJ FamilyCare is not the primary payer on an inpatient hospital claim, payment by Medicaid/NJ FamilyCare will be made at the lesser of:

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

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

(d) The State will perform a post-payment review of inpatient hospital claims for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) when Part A benefits exhaust during the inpatient hospital stay. Based on the post-payment review, the Division will determine whether paying the patient's liability for the stay will result in a lower cost to the Division. If paying the patient's liability results in a lower cost to the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

1. Where benefits have been exhausted under Medicare Part A, the charges to be billed to the Medicaid/NJ FamilyCare Program must be itemized for the Medicare Part A non-covered services in order to determine the liability of Medicare Part B and other third-party payers.

(e) Where prior authorization is required for Medicaid/NJ FamilyCare program purposes, it shall be obtained and shall be submitted with the UB-92 claim form.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote the section.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

Recodified from *N.J.A.C. 10:52-4.6* by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Former *N.J.A.C. 10:52-4.7*, Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D, recodified to *N.J.A.C. 10:52-4.8*.

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

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

Rewrote the section.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a) and (c), substituted "Medicaid/NJ" for "Medicaid or NJ" throughout.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-4.8

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.8 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D fee-for-service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services are $ 5.00 a visit for outpatient clinic visits and $ 10.00 for an emergency room visit that does not result in an inpatient hospital stay.

(c) Hospitals are required to collect the personal contribution to care for the above mentioned NJ FamilyCare-Plan C services if the NJ FamilyCare Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ FamilyCare form which indicates that the beneficiary has reached their cost share limit and no further personal contributions to care are required, until further notice. Personal contribution to care charges cannot be waived.

(d) Under NJ FamilyCare-Plan D, copayments in the amounts indicated below shall be collected by the hospital for the services as follows:

1. A $ 5.00 copayment per visit shall be required for the following services:

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

ii. Hospital outpatient department visits and diagnostic testing;

(1) For prenatal care, the $ 5.00 copayment shall apply only to the first visit;

2. A $ 25.00 copayment per visit shall be required for outpatient mental health visits; and

3. A $ 35.00 copayment per visit shall be required for outpatient emergency services including services provided in an outpatient hospital department or an urgent care facility.

i. No copayment shall be required if the beneficiary was referred to the emergency room by his or her primary care provider for services that should have been rendered in the primary care physician's office or if the beneficiary is admitted into the hospital.

4. No copayment shall be charged for the following services:

i. Outpatient surgery;

ii. Inpatient hospital services;

iii. Inpatient mental health services;

iv. Inpatient substance use disorder detoxification services; or

v. Skilled nursing facility services.

(e) Hospitals shall collect the copayment specified in (d) above except for those situations outlined in (f) below. Copayments shall not be waived.

(f) Hospitals shall not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, including well child visits and age-appropriate immunizations; for lead screenings and treatment, or for preventive dental services provided to children under the age of 12.

History

HISTORY:

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

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

Former *N.J.A.C. 10:52-4.7*, Medicaid settlement, recodified to *N.J.A.C. 10:52-4.8*.

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

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

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

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: *31 N.J.R. 998(a)*, *31 N.J.R. 1806(a)*, *31 N.J.R. 2879(b)*.

In (a), added reference to copayments for NJ KidCare-Plan D; added (d) through (f).

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

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

Substituted "FamilyCare" for "KidCare" throughout.

Recodified from *N.J.A.C. 10:52-4.7* by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Former *N.J.A.C. 10:52-4.8*, Settlement for Medicaid/NJ FamilyCare fee-for-service services, recodified to *N.J.A.C. 10:52-4.9*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (d)4iv, substituted "use disorder" for "abuse".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-4.9

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

§ 10:52-4.9 Settlement for Medicaid/NJ FamilyCare fee-for-service services

(a) The New Jersey Medicaid settlement agent for New Jersey acute care general (excluding inpatient services), special, rehabilitation, and private psychiatric and county governmental psychiatric hospitals shall determine the amount of disbursements, recoupments, and/or changes in per diem amounts and outpatient percentages, as applicable. The settlement agent shall inform the hospital and the Division of Medical Assistance and Health Services (Division/DMAHS) of the results of their review. If the settlement agent's review is accepted, DMAHS, through its fiscal agent for claims processing, shall perform the following processes:

1. For disbursements, payment shall be made to the hospital for the full amount due within 30 days from the date of settlement agent's letter.

2. The fiscal agent shall begin recoupment for the full amount of the overpayment 30 days after the date the Division receives the settlement agent's overpayment notification by withholding the Medicaid/NJ FamilyCare fee-for-service payments to the hospital.

3. If the withholding of the New Jersey Medicaid/NJ FamilyCare fee-for-service payments is not acceptable to the hospital, the hospital must submit, prior to the end of the 30-day period, a proposed repayment schedule to the Division. For a repayment schedule in excess of three months, documentation, as specified in Medicare Provider Reimbursement Manual 13-2, Section 2223, Establishing Extended Repayment, shall be submitted. If an approvable repayment schedule is not received by the Division, the withholding of Medicaid/NJ FamilyCare fee-for-service payments shall be implemented to begin recoupment.

4. The proposed repayment plans should be submitted directly to the following address:

Office of Hospital Reimbursement

Division of Medical Assistance and Health Services

PO Box 712, Mail Code #44

Trenton, New Jersey 08625-0712

5. Interest shall be charged at the maximum legal rate as of the date of the repayment agreement or 30 days from the date of the settlement agent letter to the Division, whichever is sooner.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-4.7* by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

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

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

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

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote (a).

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

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

Rewrote the section.

Recodified from *N.J.A.C. 10:52-4.8* by R.2009 d.249, effective August 3, 2009.

See: *41 N.J.R. 1351(a)*, *41 N.J.R. 2895(a)*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a)3, substituted ", as" for "(as" and "Repayment," for "Repayment)".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-5.1

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.1 Derivation of Preliminary Cost Base

For general acute care hospitals, the Division of Medical Assistance and Health Services (hereafter referred to as the Division or its designee), on or before March 12, 1993 and on or before January 31 of each subsequent rate year shall implement a rate. For hospitals with a fiscal year of January 1, the rate year will be the calendar year. For hospitals on a fiscal year beginning other than January 1, but before July 1, the rate year will be the year the fiscal year begins and for hospitals on a fiscal year beginning between July 1 and December 31, the rate year will be the year the fiscal year ends.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Deleted (a) designation.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.2

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.2 Uniform Reporting: Current costs

Hospitals shall be required to submit reports as required in N.J.A.C. 8:31B-4. The Director shall review the actual costs for the institutions as reported in accordance with the Financial Reporting Principles and Concepts (Subchapter 6). The review will be performed according to the methodology outlined below. Costs, so reported, shall be subject to revision due to subsequent audits.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.3

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.3 Costs per case

Direct and indirect care costs shall be allocated to the inpatient and outpatient services. Direct and indirect costs allocated to inpatient services shall be used to determine inpatient rates per case according to the patient diagnosis. This cost finding process is described in *N.J.A.C. 10:52-5.7* through *5.11*.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Changed N.J.A.C. reference.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Amended the N.J.A.C. reference.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-5.4

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.4 Development of standards

Effective for services provided on or after October 1, 1996, the Director shall develop standard reimbursement amounts for each DRG based on the median cost per case for Medicaid/NJ FamilyCare fee-for-service beneficiaries. The standards shall be adjusted to account for significant differences in labor market areas. These standards are developed according to criteria set forth in *N.J.A.C. 10:52-5.11* through *5.17*. Standards so developed and issued for a rate year shall remain unaffected and no adjustments, modifications, or changes to the standards shall be made except as referenced in *N.J.A.C. 10:52-5.10*.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 N.J.R. 4022(a)*, *29 N.J.R. 350(b)*.

In (a), inserted text "For services provided prior to October 1, 1996"; and added (b).

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Changed N.J.A.C. references throughout; and in (b), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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

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

In (a), inserted "(DRG)" following "Diagnosis Related Group" and amended the N.J.A.C. references in the third and fourth sentences; in (b), substituted "DRG" for "Diagnosis Related Group" preceding "based on the median cost", substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiaries", inserted "forth" following "criteria set", and amended the N.J.A.C. references in the third and fourth sentences.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted former (a) and designation (b); and substituted "Medicaid/NJ" for "Medicaid and NJ", and inserted a comma following "modifications".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.5

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.5 Current Cost Base

(a) A hospital's Current Cost Base is defined as the actual costs and revenues as identified in the Financial Elements in the base reporting period as recognized by the Division for purposes of rate setting.

(b) The Current Cost Base is used to develop the Preliminary Cost Base (PCB) and Schedule of Rates through:

1. Determination of the costs of Medicaid patients treated in the 1988 base year;
2. Identification of fixed and variable components of the Preliminary Cost Base;
3. Calculation of the economic factor cost component as defined in *N.J.A.C. 10:52-5.13(a)*;
4. Calculation of the technology factor as described in *N.J.A.C. 10:52-5.13(b)*;
5. The costs used to set rates for the rate year will be based on 1988 costs.

(c) A hospital's actual cost reports cannot be substituted or rearranged once the Director has determined that the actual cost submission is suitable for entry into the data base.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Recodified from *N.J.A.C. 10:52-5.9* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (b), changed N.J.A.C. references in 3 and 4.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.6

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.6 Financial elements reporting/audit adjustments

(a) The aggregate Current Cost Base is developed from Financial Elements reported to the Division and includes:

1. Costs related to Medicaid/NJ FamilyCare direct patient care as defined in *N.J.A.C. 10:52-6.14*;
2. Less net income from specified sources;
3. Capital facilities allowance: Capital cash requirements (as defined in *N.J.A.C. 10:52-5.14* and *6.18*);

(b) All reported financial information shall be reconciled by the hospital to the hospital's audited financial statement. In addition, having given adequate notice to the hospital, the Director may perform a cursory or detailed on-site review at the Division's discretion, of all financial information and statistics to verify consistent reporting of data and extraordinary variations in data relating to the development of the rates. Any adjustments made subsequent to the financial review, including Medicare audits and reviews, shall be brought to the attention of the Division by the hospital, the Department of Health, appropriate fiscal intermediary or payer, where appropriate, and shall be applied proportionately to the Schedule of Rates. All such adjustments shall be determined retroactively to the first payment on the Schedule of Rates and shall be applied prospectively.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-5.10* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a)3, changed N.J.A.C. reference. Former *N.J.A.C. 10:52-5.6*, Schedule of Rates, repealed.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a)1, substituted "Medicaid/NJ FamilyCare" for "Medicaid"; and in (b), substituted ", including" for "(including" and "reviews," for "reviews)", deleted "and Senior Services" following "Health", and inserted a comma following "payer" and following the second occurrence of "appropriate".

Annotations

Notes

§ 10:52-5.6 Financial elements reporting/audit adjustments

Chapter Notes

End of Document

N.J.A.C. 10:52-5.7

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.7 Identification of direct and indirect costs related to Medicaid/ FamilyCare patient care

(a) Costs related to Medicaid/NJ FamilyCare fee-for-service patient care as adjusted for price level depreciation as reported to the Division shall be classified as follows:

1. Direct patient costs:
   - i. Routine service costs;
   - ii. Ambulatory service costs; and
   - iii. Ancillary service costs.
2. Mixed direct and indirect costs.
3. Indirect patient care:
   - i. Institutional costs.

(b) Patient care general service and indirect costs (except as noted below) shall then be distributed to direct cost centers based on allocation statistics reported to the Division on the following basis:

	Patient Care General Service	Allocation Basis
CSS:	Central Supply Services	Costed requisitions
DTY:	Dietary	Patient Meals
HKP:	Housekeeping	Hours of Services
L&L:	Laundry and Linen	Pounds of Laundry
MRD:	Medical Records	Percentage of Time Spent
PHM:	Pharmacy	Cost of Drugs
EDR:	Education and Research (not including Schools of Nursing and Allied Health)	Percentage of Time Spent
RSD:	Residents	Accumulated Costs in Patient Care Cost Centers
PHY:	Physicians Coverage (related to research and medical education)	Patient Days
A&G:	Administration and General	Accumulated Cost
FIS:	Fiscal	Accumulated Cost
PCC:	Patient Care Coordination	Percentage of Time Spent
PLT:	Plant (less capitalized interest and depreciation)	Square Feet
UTC:	Utilities Cost	Square Feet
MAL:	Malpractice Insurance	Accumulated Cost
OGS:	Other General Services	Accumulated Cost

History

HISTORY:

Recodified from *N.J.A.C. 10:52-5.11* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (a), inserted a reference to NJ KidCare fee-for-service patient care in the introductory paragraph. Former *N.J.A.C. 10:52-5.7*, Extraordinary expense, repealed.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service patient care" in the introductory paragraph.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-5.8

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.8 Patient care cost findings: direct costs per case, physician and nonphysician

(a) Hospital case-mix shall be determined as follows:

1. Uniform Bill-Patient Summary (UB-PS) data shall be used for determination of hospital case-mix. The appropriate patient records for the reporting period corresponding with the Financial Elements Report shall be classified into Diagnosis Related Groups (DRGs) using the following items:

i. Principal diagnosis;

ii. Secondary diagnosis;

iii. Principal and other procedures;

iv. Age;

v. Sex;

vi. Discharge status; and

vii. Birthweight (newborn).

2. Outliers, which are defined as patients displaying atypical characteristics relative to other patients, for example, inordinately long or short lengths of stay, shall be determined by DRG using established trim points; any case beyond a trim point is considered an outlier. Hospitals must make every attempt to correct unacceptable data and hospitals for which more than 10 percent of the UB-PS data are missing or unacceptable must resubmit data or correct the unusable data before case-mix estimation will be attempted.

3. Outpatient case-mix shall consist of emergency service, clinic, home health agency, renal dialysis, home dialysis, ambulatory surgery, same day psychiatry, and private referred patients, as reported to the Division.

4. Same Day Surgical Services shall be considered a clinical, outpatient service but are assigned to a DRG and reported on a UB-PS (a bill type 13X).

(b) Measures of resource use are listed as follows:

1. For each patient with a Uniform Bill (UB), measures of resource use shall be calculated to distribute costs among the UB. Measures of resource use represent services provided to patients associated with each cost center. Patient days are associated with routine service cost, emergency room admissions with emergency service cost, and ancillary and therapeutic charges with ancillary and therapeutic service cost. The measures of resource use is a ratio of admissions reported on the hospital's cost report over the hospital's UB billing data. Costs are derived from the Actual Reporting Forms and are associated with admissions. Therefore, an adjustment is made to align the measures of resource use to the inpatient cost. The adjustment is the ratio of total admissions to total UB records. This results in a

total adjusted measure of resource use. The hospitals shall make reasonable efforts to correct data unacceptable to the Division or Department of Health.

	Center	Measure of Resource Use	Calculation of Inpatients
ROUTINE SERVICES			
MSA &	Medical-Surgical Acute Care Units	Patient Days	Total LOS less ICU, CCU, NBN and OBS LOS ACU
PED &	Pediatrics		
PSA &	Psychiatric Acute Care Units		
PSY &	Psychiatric/Psychological Services		
OBS	Obstetrics		
BCU	Burn Care Unit		BCU LOS
ICU &	Intensive Care Unit	Patient Days	ICU + CCU LOS
CCU	Coronary Care Unit		
NNI	Neonatal Intensive Care Unit	NNI Patient Days	Total ICU LOS for Newborn DRGs
NBN	Newborn Nursery	NBN Patient Days	Total LOS for Newborn DRGs less ICU LOS
AMBULATORY SERVICES			
EMR	Emergency Service	EMR Charges (Inpatient EMR Revenue and EMR Admissions)	EMR Admissions
CLN	Clinics	CLN Charges	None
HHA	Home Health	OHS Charges	None

§ 10:52-5.8 Patient care cost findings: direct costs per case, physician and nonphysician

	Center	Measure of Resource Use	Calculation of Inpatients
	Agency		
ANCILLARY SERVICES			
ANS	Anesthesiology	ANS Charges	Direct
CCA	Cardiac Catheterization	CCA Charges	Direct
DEL	Delivery and Labor Room	DEL Charges	Direct
DIA	Dialysis	DIA Charges	Direct
DRU	Drugs Sold to Patients	PHM Charges (DRU)	Direct
EKG	Electrocardiology and Diagnostic	EDG Charges	Direct
NEU	Neurology		
LAB	Laboratory	BBK Charges and LAB Charges	Direct
MSS	Medical-Surgical Supplies Sold to Patients	CSS Charges (MSS)	Direct
NMD	Nuclear Medicine	NMD Charges	Direct
OCC	Occupational and Recreational Therapy	OPM Charges	Direct
SPA	Speech Pathology and Audiology		Direct
ORG	Organ Acquisition and	ORR Charges	Direct
ORR	Operating and Recovery Rooms		
PHT	Physical Therapy	PHT Charges	Direct
RAD	Diagnostic Radiology	RAD Charges	Direct
RSP	Respiratory	RSP Charges	Direct

	Center	Measure of Resource Use	Calculation of Inpatients
THR	Therapy Therapeutic Radiology	THR Charges	Direct

(c) Cost per case allocation:

1. The Direct Patient Care Costs of each center (after the allocation of patient care general services in *N.J.A.C. 10:52-5.11* and *5.12*) are separated between inpatient, outpatient, and Skilled Nursing Facility (SNF) costs. Outpatient and SNF costs are excluded from the inpatient rates based on gross revenue reported to the Division. The total inpatient costs from each cost center are then divided by the hospital's corresponding total adjusted measure of resource use. This calculation produces ratios, including cost per patient day, cost per EMR admission, or a cost ratio per ancillary or therapeutic charge for each cost center. Each ratio is then multiplied by the corresponding cost center's measure of resource use of each DRG to calculate a cost per case for the hospital's case mix.

i. Patient days will be employed as the Measures of Resource Use to allocate MSA, PED, PSA, and OBS nursing costs. While patient days are used, the MSA, PED, PSA, OBS centers will be combined into ACU and ICU, and CCU will be combined into ICU. All other routine centers will remain as above.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Recodified from *N.J.A.C. 10:52-5.12* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a)2, substituted ", which are defined as patients" for "(patients", and substituted "stay," for "stay)"; and in (b)1, deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.9

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.9 Reasonable cost of services related to patient care

(a) The reasonable cost of services related to patient care includes:

1. Current non-physician direct patient care costs per case as adjusted by standard costs per case for Medicaid/NJ FamilyCare fee-for-service inpatients;

2. Current physician patient service costs, as modified for physician compensation arrangements pursuant to *N.J.A.C. 10:52-5.8*;

3. Indirect cost pursuant to *N.J.A.C 10:52-5.7* and *5.12*;

4. Less a reduction for income not related to patient care, from those sources specified in *N.J.A.C. 10:52-6.25* through *6.31* except all items reported as expense recovery to the Division, shall be so treated; and

5. Current major moveable equipment amount pursuant to *N.J.A.C. 10:52-6.19* and *6.24*.

(b) The reasonable cost of services related to Medicaid patient care will be adjusted by the application of economic factors pursuant to *N.J.A.C. 10:52-5.13*.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Recodified from *N.J.A.C. 10:52-5.13* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), inserted a reference to NJ KidCare fee-for-service inpatients in 1, and changed N.J.A.C. references in 2 through 4. Former *N.J.A.C. 10:52-5.9*, Current Cost Base, recodified to *N.J.A.C. 10:52-5.5*.

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

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

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service inpatients" in 1; in (b), amended the N.J.A.C. reference.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

§ 10:52-5.9 Reasonable cost of services related to patient care

In (a)5, substituted "*N.J.A.C. 10:52-6.19* and *6.24*" for "*N.J.A.C. 10:52-6.9*".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.10

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.10 Standard costs per case

(a) The standard to be used in the calculation of the proposed rates for each inpatient DRG is as follows:

1. For services provided on or after October 1, 1996, the standard to be used in the calculation of the proposed rates for each inpatient DRG is determined as the median non-physician patient care costs per Medicaid/NJ FamilyCare fee-for-service case in all hospitals whose costs are included in the data base, adjusted for labor market differentials. Standards shall be calculated across all hospitals for which current cost bases were derived from a common reporting period.

(b) Determination of the labor equalization factor to calculate Statewide standard costs per case shall be as follows:

1. An equalization factor shall be calculated for the non-physician direct patient care costs of each hospital (excluding ambulatory care centers) to account for differing hospital pay scales in the calculation of standards. Each hospital's equalization factor is determined as non-physician direct patient care costs (prior to allocation of costs from patient care general services) at average pay scales for all New Jersey hospitals (excluding those hospitals classified as Rehabilitation Facilities) divided by Labor Market Area non-physician direct patient care costs.

2. The Labor Market Areas recognized in 1990 by the Department of Health will be used for rate setting in subsequent years.

3. Labor Market Areas are:

	Counties or Municipalities
Paterson--Clifton--Passaic	Passaic
Hackensack	Bergen
Newton--Phillipsburg	Sussex, Warren
Trenton--Flemington	Mercer, Hunterdon
Newark, Suburban	Union, Essex, Somerset, Morris, except cities of

	Counties or Municipalities
	Elizabeth, Belleville, East Orange, Irvington and Newark
Jersey City	Hudson
New Brunswick--Perth Amboy	Middlesex
Long Branch--Toms River	Monmouth, Ocean
Atlantic City--Cape May	Atlantic, Cape May
Vineland--MillvilleCamden--Salem	Burlington, GloucesterCumberland
Newark, Central City (not included in v. above)	Newark, Elizabeth, Belleville, East Orange, Orange, and Irvington

4. This factor is multiplied by the hospital's actual cost per case for all DRGs.

5. Labor costs shall be adjusted to Statewide averages by first grouping all non-physician direct patient care labor costs (after fringe benefit costs have been distributed) into eight labor categories as follows:

i. Registered Nursing: Includes non-physician salaries reported in RNS, CCA, DEL, DIA and ORR cost centers.

ii. Licensed Practical Nursing: Includes non-physician salaries reported in LPN cost center.

iii. Attendants: Includes non-physician salaries reported in ATT and CSS cost centers.

iv. Clerical: Includes non-physician salaries reported in CLR cost center.

v. Health Technical: Includes non-physician salaries reported in BBK, EDG, LAB, RAD, NMD, and THR cost centers.

vi. Therapists/Technical: Includes non-physician salaries reported in OPM, PHM, PHT, and RSP cost centers.

vii. General Services: Includes non-physician salaries reported in DTY, HKP, PLT, and L&L cost centers.

viii. Administrative and Clerical: Includes non-physician salaries reported in the MRD, A&G, FIS, EDR, and PCC cost centers.

6. The portion of the routine cost centers that shall be attributed to each of the four types of nursing skill levels is based on the distribution of costs as reported to the Division.

7. By dividing non-physician direct patient care costs by the non-physician hours in each category, the average hourly rates for the eight labor categories are computed for each hospital. The sum of all of the hospital's non-physician direct patient care costs for the eight labor categories divided by the total non-physician hours is equal to the Statewide average. To determine each hospital's labor equalization factor, the Statewide average cost per hour for each labor category is multiplied by the hospital's number of non-physician labor hours for that category and is added to all other non-physician costs (that is, supplies and other costs). This amount is divided by the result of the same calculation using the Labor Market Area cost per hour, rather than Statewide average, resulting in the hospital's equalization factor.

8. Whenever the number of hospitals in a given labor market area decreases to a number less than four, the Division shall calculate and compare the mean equalization factors of the Labor Market Area, both before and after the decrease. If they differ by plus or minus one percent or more, that Labor Market Area shall be merged with the geographically contiguous Labor Market Area having the most similar hourly wage rate, averaged for all salaried employees and based on the most recent data available; the factors of all Labor Market Areas shall be recalculated and effective in the following rate year.

(c) Calculation of standards shall be as follows:

1. Effective for services provided on or after October 1, 1996, the calculation of standards shall be based on all hospital UB records for Medicaid/NJ FamilyCare patients, where Medicaid/NJ FamilyCare is the primary payor. The cost per case of each hospital's Medicaid/NJ FamilyCare patients with UB records categorized by inpatient DRGs is multiplied by each hospital's equalization factor for the appropriate DRGs and hospitals. The median equalized cost of all such records in all hospitals calculated after teaching costs have been removed from the hospitals' preliminary cost bases is the incentive standard for each DRG.

2. Determination of Labor Unequalization Factor to Calculate Standard Cost Per Case of Each Labor Market Area.

i. An unequalization factor shall be calculated for the non-physician direct patient care costs of each hospital to account for differing prevailing compensation patterns across New Jersey's Labor Market Areas in the comparison of hospital and standard costs per case. The Statewide standard times the unequalization factor is the unequalized standard in terms of the hospital's Labor Market Area.

ii. The reciprocal of the hospital's equalization factor is the hospital's unequalization factor and is applied to non-physician costs only.

(d) Effective for services provided on or after October 1, 1996, GME and IME shall no longer be reimbursed through the Medicaid/NJ FamilyCare fee-for-service hospital inpatient DRG rates. After all indirect costs have been fully allocated to the using cost centers, GME and IME costs shall be removed from the cost base before calculating the standards and Medicaid/NJ FamilyCare fee-for-service hospital inpatient rates. GME is removed by removing cost centers that contain adjusted GME costs before the direct patient care (DPC) rate is set. IME is removed from the DPC rate by multiplying by one minus the Indirect Medical Education (IME) factor based on the Medicare cost report and the fiscal agent's settlement data. GME and IME shall be reimbursed in accordance with N.J.A.C. 10:52-8.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 N.J.R. 4022(a)*, *29 N.J.R. 350(b)*.

Substantially amended section.

Recodified from *N.J.A.C. 10:52-5.14* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a)2, inserted a reference to NJ KidCare fee-for-service cases; and in (f), substituted references to Medicaid/NJ KidCare fee-for-service for references to Medicaid throughout, and changed N.J.A.C. reference. Former *N.J.A.C. 10:52-5.10*, Financial elements reporting/auditing adjustments, recodified to *N.J.A.C. 10:52-5.6*.

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

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

In (a), substituted "data base" for "date base" preceding ", and adjusted for labor market differentials" and inserted "(GME)" following "Graduate Medical education" in 1, and substituted "FamilyCare" for "KidCare" preceding "fee-for-service case" in 2; in (b), substituted "must submit a letter" for "must a submit letter" in 3ii; rewrote (f).

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In the introductory paragraph of (c)2, substituted the first occurrence of "that" for "which"; in (c)2ii(2), deleted ", Appendix XI B.I" following "8:31B"; in (c)2iii(2), deleted ", Appendix XI B.II, incorporated herein by reference" following "8:31B"; in (c)iv(2), deleted ", Appendix XI B.III" following "8:31B"; in (c)2v(2), deleted ", Appendix XI B.IV" following "8:31B"; in (c)vi(2), deleted ", Appendix XI vii" following "8:31B"; and in (d)2, substituted "by the Department of Health and Senior Services" for "rate setting at N.J.A.C. 8:31B-3.22(d)3".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

Case Notes

Burden was on hospitals to show that regulations governing hospital rates for Medicaid patients were invalid. Matter of Adoption of *N.J.A.C. 10:52-5.14(d)* 2 and *3, 276 N.J.Super. 568, 648 A.2d 509 (A.D.1994)*, certification denied *142 N.J. 448, 663 A.2d 1355*.

Division of Medical Assistance and Health Services, was not obligated to use components of Medicare rate methodology with respect to Medicaid program. Matter of Adoption of *N.J.A.C. 10:52-5.14(d)* 2 and *3, 276 N.J.Super. 568, 648 A.2d 509 (A.D.1994)*, certification denied *142 N.J. 448, 663 A.2d 1355*.

Regulations governing hospital rates for Medicaid patients were valid. Matter of Adoption of *N.J.A.C. 10:52-5.14(d)* 2 and *3, 276 N.J.Super. 568, 648 A.2d 509 (A.D.1994)*, certification denied *142 N.J. 448, 663 A.2d 1355*.

Research References & Practice Aids

LAW REVIEW AND JOURNAL COMMENTARIES:

Hospitals. Steven P. Bann, 138 N.J.L.J. No. 9, 52 (1994).

End of Document

N.J.A.C. 10:52-5.11

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.11 Reasonable direct cost per case

(a) Inpatient direct cost per case shall be determined as follows:

1. The reasonable direct cost per Medicaid/NJ FamilyCare fee-for-service case for those hospitals receiving rates in accordance with this subchapter for every DRG shall include incentives and disincentives, as appropriate, which shall be termed the boundaries of payment and are calculated as follows:

i. Effective for services provided on or after October 1, 1996, the incentive standard is multiplied by the unequalization factor and the physician mark-up.

(b) Inpatient outliers: The costs of low length of stay outliers shall be divided by the low length of stay days to arrive at a low per diem. The costs of high length of stay outliers shall be divided between both high outlier cost and the inlier rate. The high outlier cost net of the inlier rate times the high outlier cases shall be divided by the acute days of the patient's total stay (admission to discharge) to arrive at a high outlier per diem. High outlier cases shall be reimbursed the inlier rate plus the high per diem multiplied by the acute days of the stay.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 N.J.R. 4022(a)*, *29 N.J.R. 350(b)*.

In (a)1i, inserted text "Effective for services provided prior to October 1, 1996"; and added (a)1ii.

Recodified from *N.J.A.C. 10:52-5.15* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a)1, inserted a reference to NJ KidCare fee-for-service cases. Former *N.J.A.C. 10:52-5.11*, Identification of direct and indirect costs related to Medicaid patient care, recodified to *N.J.A.C. 10:52-5.7*.

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

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

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service case" in 1.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted former (a)1i; and recodified former (a)1ii as (a)1i.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-5.12

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.12 Net income from other sources

(a) The net gain (loss) from Other Operating and Non Operating Revenues (as defined in N.J.A.C. 10:52-6.25 through 6.32) and expenses of the reporting period which are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 10:52-6.25 through 6.32) as reported to the Division is subtracted from (added to) indirect costs of the Preliminary Costs Base.

(b) Such revenue shall include all Other Operating and Non Operating Revenues and Expenses reported per Standard Hospital Accounting and Rate Evaluation (SHARE) cost center costs and "expense recoveries" as Case B and all other items reported as to their case specified in N.J.A.C. 10:52-6.25 through 6.32.

History

HISTORY:

Recodified from N.J.A.C. 10:52-5.16 and amended by R.2000 d.29, effective January 18, 2000.

See: 31 New Jersey Register 3151(a), 32 New Jersey Register 276(a).

Changed N.J.A.C. references throughout. Former N.J.A.C. 10:52-5.12, Patient care cost findings; direct costs per case, physician and nonphysician, recodified to N.J.A.C. 10:52-5.8.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-5.13

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.13 Update factors

(a) The economic factor is the measure of the change in prices of goods and services used by New Jersey hospitals. The economic factor will be the factor recognized under the TEFRA target limitations.

1. The hospital-specific economic factor is the weighted average of the recorded and projected change in the value of its components. The weight given to each component is its share of that hospital's total expenditure. The projection of individual components shall be based, where appropriate, on legal or regulatory changes which fix the future value of a proxy. Components which are of particular importance may be projected through the use of time series analysis or other relevant indicators.

(b) The technology factor takes into account the costs of adopting quality enhancing technologies.

(c) Base-year direct patient care and indirect rates shall be multiplied in succeeding years by a technology factor to provide prospective funds to support hospital adoption of quality-enhancing technologies. The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Medicare Payment Advisory Commission (MedPAC). The factor shall be composed of the proportion of incremental operating costs associated with MedPAC's identified cost-increasing technologies, and MedPAC's allowance for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by MedPAC.

(d) In addition, the following payment rates will be in effect for these special procedures:

1. Liver Transplants: payment for DRG 480 will be $ 72,139 in 1988 dollars.

2. Heart Transplants: payment for DRG 103 will be $ 72,438 in 1988 dollars.

3. Cochlear Implants: payment for DRG 759 will be $ 21,608 in 1988 dollars.

4. Bone Marrow Transplants: payment for DRG 481 will be $ 46,599 in 1988 dollars.

5. Neonate rates: payment for neonatal DRGs as defined by New Jersey Grouper 8.0 will be based on 1989 actual New Jersey patient volume.

(e) For determination of the payment rates, direct patient care is increased for the following components:

1. Indirect patient care for items other than listed in *N.J.A.C. 10:52-5.7*;

2. Health Planning fees;

3. Capital facilities allowance;

4. Physician fee for service;

5. Child psychiatric hospital direct and indirect;

6. Resident count correction (only for services provided prior to October 1, 1996).

7. Special perinatal expense adjustment;

8. Trauma center adjustment;

9. GME reversal (only for services provided prior to October 1, 1996);

10. Hemophilia adjustment;

11. Regional perinatal adjustment;

12. Personnel health allowance;

13. Pediatric rate adjustment;

14. Sickle cell adjustment;

15. Continuous adjustments;

16. Outlier reversal adjustment; and

17. Poison Control Costs.

(f) No Statewide transition adjustment not otherwise specified in this chapter will be included in the rate.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 N.J.R. 4022(a)*, *29 N.J.R. 350(b)*.

In (a)6 and (a)9, added text "(only for services provided prior to October 1, 1996)".

Recodified from *N.J.A.C. 10:52-5.17* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (e)1, changed N.J.A.C. reference. Former *N.J.A.C. 10:52-5.13*, Reasonable cost of services related to patient care, recodified to *N.J.A.C. 10:52-5.9*.

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

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

In (a), added 1; in (b), deleted 1; in (c), substituted references to the Medicare Payment Advisory Commission (MedPAC) for references to the Prospective Payment Assessment Commission (ProPAC) throughout.

Annotations

Notes

Chapter Notes

Case Notes

§ 10:52-5.13 Update factors

Interpretation of *N.J.A.C. 10:52-5.17(a)* (recodified as *N.J.A.C. 10:52-5.13(a)*) urged by a hospital relative to DMAHS's calculation of its 1995 Medicaid reimbursement rate for inpatient hospital services did not provide assurance that the Medicaid payments would not exceed those that applied for the purpose of Medicare rates did not achieve the dual purposes of the regulation, which was to create an inflation adjustment and provide the assurance required by *42 C.F.R. § 447.272(a) (1992)* that Medicaid payments did not exceed Medicare payments. The canon of interpretation on which the hospital was relying resulted in an interpretation that conflicted with one of those two purposes and thus was properly rejected. *Our Lady of Lourdes Hosp. - Burlington v. DMAHS, OAL DKT. NO. HMA 04005-06, 2015 N.J. AGEN LEXIS 506*, Initial Decision (November 25, 2015).

End of Document

N.J.A.C. 10:52-5.14

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.14 Capital facilities

(a) Capital Facilities, as defined in *N.J.A.C. 10:52-6.18*, shall be included in the rate in the following manner:

1. Building and fixed equipment:

i. The yearly Capital Facilities Allowance is computed using information provided by the Share Cost Reports. For hospitals on a calendar year basis, this amount will be its 1992 depreciation and interest expense, excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery. For those hospitals on a fiscal year basis, actual year's depreciation and interest applicable to rate year 1992 shall be used excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery.

ii. Effective for services provided on or after October 1, 1996, all building and fixed depreciation and interest capital costs as defined in *N.J.A.C. 10:52-6.18* related to GME programs shall be determined based on the 1992 audited Medicare Cost Report (HCFA-2552) and shall be excluded from the base year cost used to calculate the Medicaid DRG inpatient rates.

2. Major Moveable Equipment: For the purpose of calculating the Price Level Depreciation Allowance, Major Moveable Equipment is grouped into four categories based on the cost center function where the equipment is utilized: Beds and nursing equipment; Diagnostic and therapeutic equipment; General service equipment; and Business service equipment.

i. The following rules shall apply in calculating the Price Level Allowance for a given year:

(1) Only equipment which has not been fully depreciated at the start of the fiscal year is to be used in the calculation of the Price Level Allowance.

(2) The depreciation recorded and reported on all equipment subject to the Price Level Allowance must be calculated by the straight-line method, using at the time of the cost filing the most recent approved American Hospital Association (AHA) Recommended Useful Life (that is, 1978 revision) or Asset Depreciation Range (ADR).

(3) Only capitalized equipment and related capitalized costs can be used in the calculation of the Price Level Allowance.

(4) The price level factors for each of the four categories will be developed by the Division. For years prior to current cost base year, the factors to be used for price leveling depreciation are as follows:

Category	**Proxy**
Beds and Nursing Equipment	Marshall and Swift Hospital Equipment Cost Index

Category	Proxy
Diagnostic and Therapeutic Equipment	Marshall and Swift Hospital Equipment Cost Index
General Service Equipment	Producer Price Index (PPI) 1161, Food Products Machinery (41.18%), PPI 1241.02, Laundry Equipment (23.53%). PPI 113 less 1134 and 1136, Metalworking Machinery less Industrial Furnaces and Abrasive Products (35.29%).
Business Service Equipment	PPI 1193 less 1193.06, Business and Store equipment (less Coin Operated Vending Machines) and PPI 122, Commercial Furniture.

(5) Assets retired before the close of the fiscal year are not to be used in the calculation of the Price Level Allowance.

(6) The amount of the Price Level Allowance shall be calculated as follows:

(A) Current year straight-line depreciation of each asset being depreciated is multiplied by the price level factor corresponding to the year the asset was acquired to determine price level depreciation. Straight-line depreciation is then subtracted from price level depreciation and the result totaled to determine the amount of the Price Level Allowance provided by the following calculation: Algebraically the calculation is as follows:

D . . .	(equals) Current year depreciation, ordered by the year of acquisition of the asset being depreciated.
F . . .	(equals) Price level factor for the year the asset was acquired.
PLA . . .	(equals) Price Level Allowance.
PLA . . .	(equals) (D x F) - D.

(7) The interest component of cash disbursements relative to capitalized Major Moveable Equipment leases is to be classified as interest expense, in accordance with GAAP, and not used as a basis for calculating the price level depreciation premium.

(8) The total Price Level Allowance will be allocated to cost centers based upon the accumulated depreciation of all Major Moveable Equipment not fully depreciated.

(b) Any new capital facilities construction with a valid certificate of need from the New Jersey Department of Health may request a capital facilities adjustment in rates through the review and appeal process as described in N.J.A.C. 10:52-9, except that a hospital which meets the requirements of (b)1 below may request a capital facilities adjustment in accordance with (b)2 below.

1. A hospital may submit an appeal specific to its CFA without going through the full rate review process, if:

i. The appeal is for a single capital project in excess of $ 20 million which is for replacement beds which reduce the number of hospital beds available in the State and as of September 15, 1997, the hospital has an approved certificate of need for this project;

ii. The hospital receives no direct State appropriation; and

iii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low-income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low-income revenue percentage shall be based on the sum of the Medicaid/NJ FamilyCare revenue as reported on Forms E-5 and E-6, line 1, column E, plus the Charity Care revenue as reported on Forms E-5 and E-6, line 1, column J, divided by the sum of the total revenue as reported on Forms E-5 and E-6, line 1, column M.

2. If all of the conditions in (b)1 above are met, the hospital shall submit all supporting documentation to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, PO Box 712, Mail Code #44, Trenton, New Jersey 08625-0712. The Division shall issue a written determination once the supporting documentation is reviewed and the hospital may appeal the determination pursuant to *N.J.A.C. 10:52-9.1(d)*.

3. In addition to an adjustment to its rates, a hospital that meets the condition of (b)1 above shall receive an additional payment for its Capital Project Funding related to its Medicaid/NJ FamilyCare-Plan A managed care utilization.

i. Payments to eligible hospitals shall begin upon project completion and facility operation.

ii. The hospital-specific Capital Project Funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid/NJ FamilyCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 N.J.R. 4022(a)*, *29 N.J.R. 350(b)*.

Deleted (a)1i, relating to capital cash requirements; recodified former (a)1ii as (a)1i and deleted subparagraph 1 of that paragraph; and inserted new (a)1ii.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

In (b), added the exception; and added (b)1 and (b)2.

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

Added (b)3.

Recodified from *N.J.A.C. 10:52-5.18* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), changed N.J.A.C. references throughout, and substituted a reference to the Office of Provider Rate Setting for a reference to Administrative and Financial Services in 2. Former *N.J.A.C. 10:52-5.14*, Standard costs per case, recodified to *N.J.A.C. 10:52-5.10*.

Amended by R.2004 d.194, effective May 17, 2004.

See: *36 N.J.R. 323(a)*, *36 N.J.R. 2424(a)*.

In (b), substituted "N.J.A.C. 10:52-9" for "N.J.A.C. 10:52-8" in the introductory paragraph, amended the Mail Code and N.J.A.C. reference in 2, and rewrote 3i.

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

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

In (b), amended the address in 2; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (b), made grammatical and/or technical changes regarding references to Medicaid, NJ FamilyCare, and the Department of Health throughout; in the introductory paragraph of (b), inserted a comma following the N.J.A.C. reference; in (b)1iii, substituted "low-income" for "low income" twice; and in (b)3, substituted "that" for "which".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-5.15

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.15 Division adjustments and approvals

(a) Any modifications including any statutory or regulatory changes or changes in patient care physician compensation arrangements shall be classified as direct or indirect, and as to the financial elements affected and each element adjusted proportionately.

(b) The Division shall also approve adjustments to hospitals' Schedules of Rates for 1993 and subsequent years as necessary to subtract approved costs associated with residents not meeting the minimum requirements as defined in *N.J.A.C. 10:52-5.10(b)*; for any costs associated with residents in programs which have lost accreditation as defined in *N.J.A.C. 10:52-5.10(b)*; and for any costs associated with previously approved but now vacant residency positions which are unfilled as a result of a hospital's inability to recruit residents meeting these minimum standards. These costs shall include, but are not limited to, resident salaries and fringes, faculty salaries, malpractice and supplies.

(c) The Division may approve hospital appeals to transfer Division approved resident positions and associated costs between hospitals. A hospital may appeal under any option to reduce or increase the number of resident positions by transfer. An addition of resident positions by transfer may not result in a change to a higher teaching status peer group. A reduction of resident positions by transfer may result in a change to a lower teacher status peer group. The approved costs associated with a transferred resident position may not increase solely as a result of the transfer.

(d) The Division shall decide to which hospitals the approved resident positions and associated costs may be transferred.

(e) Subsections (a) through (d) above apply for dates of services provided prior to October 1, 1996. Effective for services provided on or after October 1, 1996, this section is no longer applicable.

History

HISTORY:

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 New Jersey Register 4022(a)*, *29 New Jersey Register 350(b)*.

Added (e).

Recodified from *N.J.A.C. 10:52-5.19* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (b), changed N.J.A.C. references throughout. Former *N.J.A.C. 10:52-5.15*, Reasonable direct cost per case, recodified to *N.J.A.C. 10:52-5.11*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.16

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.16 Derivation from Preliminary Cost Base

(a) Apportionment of Financial Elements based on direct costs shall be as follows:

1. All other Financial Elements are added to direct Medicaid/NJ FamilyCare fee-for-service patient care costs as percentages of direct costs per Medicaid/NJ FamilyCare case. The Schedule of Rates is set such that all Medicaid/NJ FamilyCare patients' rates are based on the cost of services received by Medicaid/NJ FamilyCare fee-for-service beneficiaries, including a proportionate share of indirect financial elements requirements of operating hospital facilities.

2. In the event that a hospital is self-insured for employee health benefits, the percentage of personnel health allowance recognized in the rates shall be proportioned to the number of Medicaid/NJ FamilyCare fee-for-service beneficiaries serviced by the facility to financial elements from payers for such costs.

3. Each hospital shall receive from the Division a base rate order detailing the Schedule of Rates.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Recodified from *N.J.A.C. 10:52-5.20* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (a), substituted a reference to Medicaid NJ KidCare fee-for-service patient care costs for a reference to Medicaid patient care costs, inserted a reference to NJ KidCare cases, and substituted a reference to Medicaid/NJ KidCare patients' rates for a reference to Medicaid patients' rates in 1, and substituted references to Medicaid and NJ KidCare fee-for-service beneficiaries for references to Medicaid recipients in 1 and 2. Former *N.J.A.C. 10:52-5.16*, Net income from other sources, recodified to *N.J.A.C. 10:52-5.12*.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Substituted "FamilyCare" for "KidCare" throughout.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.17

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.17 Schedule of rates--effective date

All rates issued pursuant to this subchapter, as approved or modified, shall be effective as of October 1, 1996, of the rate year and then January 31 for subsequent years.

History

HISTORY:

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 New Jersey Register 4022(a)*, *29 New Jersey Register 350(b)*.

Amended effective date.

Recodified from *N.J.A.C. 10:52-5.21* and amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Substituted a reference to January 31 for a reference to January 1. Former *N.J.A.C. 10:52-5.17*, Update factors, recodified to *N.J.A.C. 10:52-5.13*.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Deleted "except for fiscal year hospitals whose rates shall be effective as of the first day of the "fiscal" rate year".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-5.18

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.18 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:52-5.14* by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.19

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.19 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:52-5.15* by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.20

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.20 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:52-5.16* by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-5.21

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

§ 10:52-5.21 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:52-5.17* by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.1

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.1 Reporting principles

The reporting principles and concepts adopted by the Department of Health at N.J.A.C. 8:31B-4.1 through 4.25 shall be used for Medicaid/NJ FamilyCare fee-for-service rates.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (a), substituted a reference to Medicaid/NJ KidCare fee-for-service rates for a reference to Medicaid rates.

Repeal and New Rule, R.2005 d.214, effective July 5, 2005.

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

Section was "Reporting period".

Amended by R.2018 d.104, effective May 21, 2018.

See: 49 N.J.R. 3294(a), 50 N.J.R. 1261(a).

Deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.2

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.2 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Objective evidence".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.3

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.3 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Consistency".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.4

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.4 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Full disclosure".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.5

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.5 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Materiality".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-6.6

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.6 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Basis of valuation".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.7

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.7 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Accrual accounting".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.8

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.8 (Reserved)

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (a), inserted ", but is not limited to," following "includes", and substituted "and buckets" for ", buckets, etc." following "mops" in the introductory paragraph.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Accounting for minor moveable equipment".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.9

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.9 (Reserved)

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (b), inserted ", but are not limited to," following "include", and substituted "and walls" for ", walls, etc." following "fences"; and in (g)6i, changed N.J.A.C. reference.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Accounting for capital facilities costs".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.10

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.10 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Timing differences".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.11

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.11 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Self-insurance".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.12

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.12 (Reserved)

History

HISTORY:

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Related organizations".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.13

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.13 Financial elements (generally)

The financial elements of the rates shall include the reasonable cost of the following: direct patient care; depreciation expense and interest payments; paid taxes, excluding income taxes; education, research and training programs, not otherwise paid for by the State; and preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements. All non-direct costs must be allocated based upon the proportion of Medicaid/NJ FamilyCare fee-for-service beneficiaries serviced by the hospital.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Substituted a reference to Medicaid/NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Substituted "State; and preservation" for "State; preservation" preceding ", replacement and improvement", deleted "; reasonable working capital; and where applicable and appropriate, reasonable return on investment" following "planning requirements", and substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiaries".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.14

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.14 Services related to Medicaid/NJ FamilyCare fee-for-service patient care

(a) Services related to Patient Care include Direct Patient Care; Paid Taxes excluding Income Taxes; and Educational, Research and Training Programs as further defined in *N.J.A.C. 10:52-6.15* through *6.17*.

(b) Services Related to Patient Care include Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services. Costs Related to Patient Care include salaries and wages, physician compensation, employee fringe benefits, medical and surgical supplies, drugs, non-medical and non-surgical supplies, purchased services and other direct expenses and major moveable equipment costs as determined in accordance with *N.J.A.C. 10:52-6.20* through *6.24*.

(c) All non-physician services and supplies provided to hospital inpatients, whether provided directly by the hospital or by a vendor, shall be considered services and costs related to patient care.

(d) All costs of services and supplies purchased from a vendor shall be subject to review for reasonableness by the Division.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a) and (b), deleted "Medicaid" preceding "Patient", and changed N.J.A.C. references.

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

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

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (a), substituted "10:52-6.15" for "10:52-6.14".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.15

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.15 Direct patient care

Direct patient care is the provision by a hospital of medically necessary and appropriate health care services to a Medicaid/NJ FamilyCare fee-for-service beneficiary.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

Deleted "Medicaid" at the beginning, and substituted a reference to MEdicaid/NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiary".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-6.16

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

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

§ 10:52-6.16 Paid taxes

Taxes are monies paid to a governmental unit for conducting business related to direct patient care within its jurisdiction. Taxes are a financial element of the Preliminary Cost Base except for Federal, State, or local income, excess profit, or franchise taxes, taxes on property not used for direct patient care, and interest and/or penalties paid thereon. Taxes related to financing of operations through the issuance of bonds, property transfers, issuance or transfer of stocks, and the like, are not classified as taxes; rather, they shall be amortized or depreciated with the cost of the security or asset. Sales and real estate taxes paid by a hospital in the provision of Services Related to Patient Care shall be included as Paid Taxes. All sales and real estate taxes for Services Related to Patient Care shall be reported in the General Administrative Services cost center and also reported separately from other classifications of expense. Employment related taxes, such as FICA, Unemployment Compensation, and Workers' Compensation, shall be classified as employee fringe benefits for all employees, including hospital-based physicians. Monies received by a hospital which chooses to self-insure in lieu of payment of Unemployment Compensation taxes and the associated administrative costs of such a self-insurance program are included as financial elements and classified as employee fringe benefits, if such monies are reasonably related to the hospital's unemployment compensation experience.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-7.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

§ 10:52-7.1 Diagnosis Related Groups (DRG)

(a) Diagnosis Related Groups (DRG) represent categories of hospital inpatients with similar clinical characteristics and, except for outliers, patients in each DRG can be expected to consume similar amounts of hospital resources. Assignment of a patient to a DRG requires the following information:

1. Principal diagnosis;

2. Secondary diagnosis;

3. Principal and other procedures;

4. Age;

5. Sex;

6. Discharge status; and

7. Birthweight (neonate): A newborn under 29 days of age.

(b) The appropriate classifications are reported here and these are the only classifications allowable for DRG assignment.

1. Principal diagnosis: The condition established after study shall be chiefly responsible for occasioning the admission of a patient to the hospital for care. The principal diagnosis must be coded using the International Classification of Diseases, 10th Revision, with Clinical Modifications (ICD-10-CM).

2. Secondary diagnosis: Conditions that exist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay. Diagnoses which have no bearing on the treatment received during a current hospital stay are not appropriate for use in DRG assignment. All secondary diagnoses must be coded using ICD-10-CM.

3. Principal and other procedures: Diagnostic and therapeutic procedures performed during a patient stay. All procedures must be coded using ICD-10-CM.

4. Age: Patient's chronological age at admission in years.

5. Sex: Patient's sex as male or female.

6. Discharge Status: The circumstances under which a patient left the hospital, coded as routine discharge to home, discharged against medical advice, transferred or died.

7. Birthweight: A newborn's weight in grams at birth.

8. Neonate: A newborn under 29 days of age.

(c) Admission: Patient hospitalized for a condition related to a recent spell of illness.

1. Patients who are treated and subsequently admitted through the emergency room shall be considered admitted to the hospital at the time the physician orders the admission. The cause of the admission shall be considered the cause of the emergency room treatment. Therefore, the course of

treatment shall be considered one admission. Services rendered in the emergency room shall be reflected in the inpatient record and UB-92 claim form.

2. Similarly, a patient admitted for a course of treatment as a Same Day Surgery (SDS) patient, who subsequently is admitted from that mode of treatment shall be considered one admission. Services rendered in the SDS mode shall be reflected in the inpatient record and UB-92 claim form.

3. Readmissions are patients admitted to an acute care hospital at another time during the last seven days.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (c), substituted references to UB-92 claim forms for references to UB-82 claim forms in 1 and 2.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (b)1, substituted "10th" for "9th"; and in (b)1 through (b)3, substituted "ICD-10-CM" for "ICD-9-CM".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-7.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

§ 10:52-7.2 Calculation of payment rates

(a) Outliers are patients displaying atypical characteristics relative to other patients in a DRG. The three categories of outliers are defined and the methodology for outlier payment is established as follows.

1. High length of stay: Patients assigned to a DRG, but whose Length of Stay (LOS) is longer than the high LOS trim point.

i. The rate is the inlier rate per case plus a per diem for each acute day from the date of admission to the date of discharge.

2. Low length of stay: Patients assigned to a DRG, but whose Length of Stay (LOS) is shorter than the trim point.

i. Payment is limited to either the lower of the inlier rate per case or the sum of the acute days multiplied by the low per diem.

3. Transfer patients: Patients under medical advice requiring continued acute care who are transferred from one Acute Care Facility to another Acute Care Facility.

i. Where a patient's discharge status is that of a transfer to another acute care facility (inpatient), the rate is limited to the lower of the inlier rate per case or the sum of the acute days multiplied by the low outlier per diem. The hospital which received the transfer patient (and that patient is subsequently a non-transfer status discharge) will receive the appropriate rate per case or per diem based upon DRG assignment and trim point status.

4. The payment rates for DRGs with no base year experience will be calculated using Medicaid Statewide base year costs.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 New Jersey Register 34(a), 27 New Jersey Register 908(a).

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-7.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

§ 10:52-7.3 List of Diagnosis Related Groups

(a) The following are Major Diagnostic Categories (Organ System Approach):

1. Diseases and Disorders of the Nervous System.

2. Diseases and Disorders of the Eye.

3. Diseases and Disorders of the Ear, Nose, Mouth and Throat.

4. Diseases and Disorders of the Respiratory System.

5. Diseases and Disorders of the Circulatory System.

6. Diseases and Disorders of the Digestive System.

7. Diseases and Disorders of the Hepatobiliary System and Pancreas.

8. Diseases and Disorders of the Musculoskeletal System and Connective Tissue.

9. Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.

10. Endocrine, Nutritional and Metabolic Diseases and Disorders.

11. Diseases and Disorders of the Kidney and Urinary Tract.

12. Diseases and Disorders of the Male Reproductive System.

13. Diseases and Disorders of the Female Reproductive System.

14. Pregnancy, Childbirth and the Puerperium.

15. Normal Newborns and Other Neonates with Certain Conditions Originating in the Perinatal Period.

16. Diseases and Disorders of Blood and Blood Forming Organs and Immunological Disorders.

17. Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms.

18. Infectious and Parasitic Diseases (Systemic or Unspecified Sites).

19. Mental Diseases and Disorders.

20. Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.

21. Injuries, Poisonings and Toxic Effects of Drugs.

22. Burns.

23. Factors Influencing Health Status and Other Contacts with Health Services.

24. Human Immunodeficiency Virus (HIV) Infections.

25. Multiple Significant Trauma.

(b) The following are abbreviations used in ICD-10-CM DRG English descriptors.

1. W AGE 70 CC: Patients who are over age 70 and have a substantial complication or co-morbidity.

2. WO AGE 70 CC: Patients who are over age 70 and have no substantial complication or co-morbidity.

3. W CC: Patients with a substantial complication or co-morbidity.

4. WO CC: Patients without a substantial complication or co-morbidity.

5. O.R. Procedures: therapeutic or diagnostic procedures generally performed in a fully equipped operating room (O.R.).

6. URI: Upper Respiratory Infection.

7. AMI: Acute Myocardial Infarction.

8. CHF: Congestive Heart Failure.

9. D & C: Dilation and Curettage.

10. FUO: Fever of Unknown Origin.

11. NEC: Not Elsewhere Classifiable.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

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

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

In (b), deleted '/or" preceding "have a substantial complication" in 1 and substituted "who are over age 70" for "who are age 0-70" preceding "and have no substantial complication" in 2.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (b), substituted "ICD-10-CM" for "ICD-9 CM".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-8.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

§ 10:52-8.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed

(a) Medicare principles of reimbursement for GME and IME are as follows:

1. Direct GME is calculated based on Medicaid's and NJ FamilyCare-Plan A's fee-for-service share of the major teaching hospitals' intern and resident FTEs multiplied by their specific per resident amounts as reported on the Medicare audited cost report (including subsequent amendments) in Worksheet E-3 Part IV for the year in which payment has been made.

2. IME is calculated based on Medicare's IME formula, at *42 CFR 412.105*, incorporated herein by reference. The major teaching hospitals' IME factor, as calculated by the Medicare IME formula, is multiplied by their hospital-specific Medicaid/NJ FamilyCare-Plan A fee-for-service inpatient DRG payments (net of GME and IME) to arrive at the Medicaid/NJ FamilyCare-Plan A fee-for-service IME payment. The components of Medicare's IME formula, IME intern and resident FTEs and maintained beds, are from the audited Medicare cost report (including subsequent amendments) in Worksheet S-3 for the year in which payment has been made.

History

HISTORY:

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

In (a), inserted "and prior to July 6, 1998," following "1996,"; and in (b), inserted references to NJ KidCare-Plan A fee-for-service throughout.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted former (a); recodified former (b) as (a); and in (a)2, substituted "CFR" for "C.F.R.", and substituted "Medicaid/NJ" for "Medicaid and NJ" twice.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-8.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

§ 10:52-8.2 (Reserved)

History

HISTORY:

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

Inserted "and prior to July 6, 1998" following "1996,", and inserted references to NJ KidCare-Plan A fee-for-service days throughout.

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Changed N.J.A.C. reference.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

Repealed by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Distribution of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement".

Annotations

Notes

Chapter Notes

§ 10:52-8.2 (Reserved)

End of Document

N.J.A.C. 10:52-8.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

§ 10:52-8.3 (Reserved)

History

HISTORY:

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

Inserted "and prior to July 6, 1998" in the first and third sentences, and inserted references to NJ KidCare-Plan A fee-for-service throughout.

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted references to the Division's settlement agent for references to Blue Cross and Blue Shield of New Jersey and changed N.J.A.C. references throughout.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

Repealed by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Establishment of GME and IME interim method of reimbursement".

Annotations

Notes

Chapter Notes

§ 10:52-8.3 (Reserved)

End of Document

N.J.A.C. 10:52-8.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

§ 10:52-8.4 (Reserved)

History

HISTORY:

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

Inserted "and prior to July 6, 1998" and inserted a reference to NJ KidCare-Plan A fee-for-service in the first sentence.

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Changed N.J.A.C. references throughout.

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

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

Substituted "FamilyCare" for "KidCare".

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Substituted "10:52-8.3" for "10:52-4.7(a)1 through 5".

Repealed by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Establishment of GME and IME final method of reimbursement".

Annotations

Notes

Chapter Notes

§ 10:52-8.4 (Reserved)

End of Document

N.J.A.C. 10:52-8.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

§ 10:52-8.5 Hospital fee-for-service reimbursement for Graduate Medical Education (GME) effective on or after July 6, 1998

(a) Effective for payments on or after July 6, 1998, the GME payment shall be distributed in 12 monthly lump sum payments during the State Fiscal Year. The amount distributed shall be considered the final GME payment and shall not be reconciled. The GME payment shall not exceed the amount appropriated for GME each State Fiscal Year. This GME payment represents both direct GME and Indirect Medical Education (IME).

(b) The source of the data used to allocate the GME payment is the Medicare/Medicaid submitted cost report that is on file with DMAHS as of October 31 of the current calendar year for GME payments for the State fiscal year commencing July 1 of the subsequent year with corresponding 24-month fee-for-service Medicaid/NJ FamilyCare-Plan A inpatient paid claims data as of February 1 prior to the year of distribution. GME resident full-time-equivalents and total hospital days shall come from the Medicare/Medicaid/NJ FamilyCare submitted cost report. The hospital-specific Medicaid/NJ FamilyCare-Plan A fee-for-service days shall come from the 24-month data fee-for-service Medicaid/NJ FamilyCare-Plan A inpatient paid claims data.

1. For hospitals with psychiatric units included in the Medicare Inpatient Prospective Reimbursement System for Medicare reporting purposes but excluded for Medicaid/NJ FamilyCare reporting purposes, the data from the hospital-submitted worksheets for the Medicaid-excluded psychiatric units shall be used.

(c) The intern and resident full-time equivalents (FTEs) as reported on the Medicare submitted cost report may be audited by the Division or its agent prior to payment. An adjustment, if necessary, to the submitted intern and resident FTEs shall be made in accordance with the audit.

History

HISTORY:

New Rule, R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

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

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

In (c), deleted "of Medical Assistance and Health Services" following "Division"; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Added (b)1.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Rewrote (b).

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-8.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

§ 10:52-8.6 Distribution of Graduate Medical Education (GME) effective on or after July 6, 1998

(a) Effective for payments on or after July 6, 1998, the amount appropriated for GME shall be distributed to all eligible acute care teaching hospitals. An eligible acute care teaching hospital is defined as an acute care teaching hospital that has a combined Medicaid/NJ FamilyCare-Plan A fee-for-service utilization at or above the median of all New Jersey acute care hospitals. The Medicaid/NJ FamilyCare-Plan A fee-for-service utilization is calculated using the hospital-specific Medicaid/NJ FamilyCare-Plan A fee-for-service days divided by the hospital-specific total days.

(b) The distribution of the GME payment to eligible acute care teaching hospitals is based on the hospital-specific percentage of total weighted GME FTEs, where weighted GME FTEs equals the hospital-specific GME FTEs times the hospital-specific Medicaid/NJ FamilyCare-Plan A fee-for-service days divided by the total Medicaid/NJ FamilyCare-Plan A hospital fee-for-service days for all eligible hospitals.

History

HISTORY:

New Rule, R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

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

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

In (b), deleted 1; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-9.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

§ 10:52-9.1 Review and appeal of rates

(a) All hospitals, within 15 working days of receipt of the Proposed Schedule of Rates shall notify the Division of any calculation errors in the rate schedule that relate to adjustments that have been made to the rates since the previously announced schedule of rates. If upon review it is determined by the Division that the error is of substantial value, a revised rate will be issued to the hospital within 10 working days. If the discrepancy is determined to be substantial and a revised Schedule of Rates is not issued by the Division within 10 working days, notification time frames above will not become effective until the hospital receives a revised Schedule of Rates.

(b) Any hospital which seeks an adjustment to its rates shall agree to an operational review at the discretion of the Department.

1. A request for a rate review must be submitted by a hospital in writing to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, PO Box 712, Mail Code #44, Trenton, New Jersey 08625-0712 within 20 calendar days after publication of the rates by the Department of Human Services (DHS).

i. A hospital shall identify its rate review issues and submit supporting documentation in writing to the Division within 80 calendar days after publication of the rates by the DHS.

2. The Division will not approve an increase in a hospital's rates unless the hospital demonstrates that it would sustain a marginal loss in providing inpatient services to Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries at the rates under appeal even it if were an economically and efficiently operated hospital. Marginal loss is the amount by which a hospital's rate year's Medicaid/NJ FamilyCare-Plan A fee-for-service reimbursement for inpatient services including Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments is expected to fall short of the incremental costs, defined as the variable or additional out of pocket costs, that the hospital expects to incur providing inpatient hospital services to Medicaid/NJ FamilyCare-Plan A fee-for-service patients during the rate year. These incremental costs are over and above the inpatient costs the hospitals would expect to incur during the rate year even if it did not provide service to Medicaid/NJ FamilyCare-Plan A fee-for-service patients. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries and the extent to which it has taken all reasonable steps to contain or reduce the costs of providing inpatient hospital services. The hospital may be required at a minimum to submit to the Department of Human Services, the following information:

i. Operational reviews;

ii. Efficiency studies and reports identifying opportunities for cost savings;

iii. Minutes of the meeting of the hospital's board of directors and board's finance committee;

iv. Reports of the Joint Commission on the Accreditation of Health Care Organizations;

v. Management letters;

vi. The hospital's strategic plans, long range plans, facilities plans and marketing plans;

vii. The hospital's annual report;

viii. Any analyses of the hospital's marginal cost in providing services to Medicaid/NJ FamilyCare-Plan A fee-for-service or other categories of patients;

ix. Cost accounting documentation or reports pertaining to the hospital's cost incurred in treating Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries or the comparative cost of treating Medicaid/NJ FamilyCare-Plan A fee-for-service and other patients;

x. A copy of the hospital's most recent Medicare cost report with all supporting schedules;

xi. Contracts with other payors providing for negotiated rates or discounts from billed charges; and

xii. Evidence that the appealed rates jeopardize the long term financial viability of the hospital (that is, that the hospital is sustaining a marginal loss in treating Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries) and that the hospital is necessary to provide access to care for Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries.

(c) The Division shall review the documentation and determine if an adjustment is warranted.

(d) The Division shall issue a written determination with an explanation as to each request for a rate adjustment. If a hospital is not satisfied with the Division's determination, the hospital may request an administrative hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an administrative hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying or rejecting the Administrative Law Judge's initial Office of Administrative Law decision. Thereafter, review may be had in the Appellate Division.

History

HISTORY:

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: *28 N.J.R. 4022(a)*, *29 N.J.R. 350(b)*.

Added (b)2, inserted provisions defining marginal loss and incremental costs; and in (d), inserted provision providing time period for an administrative hearing request.

Amended by R.1997 d.541 effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), substituted a reference to the Office of Reimbursement Services for a reference to the Office of Budget, Fiscal Affairs and Information Systems in 1, and substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare Plan--A fee-for-service throughout 2.

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

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

In (a), rewrote the first sentence; in (b), deleted "of Human Services" following "Department" in the introductory paragraph, substituted "Hospital Reimbursement" for "Reimbursement Services" and "44" for "49" in the introductory paragraph of 1, and inserted "including Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments" following "inpatient services" in 2; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (b), substituted "Medicaid/NJ" for "Medicaid and NJ" throughout.

Annotations

Notes

Chapter Notes

Case Notes

Existence of state's administrative process did not preempt hospital association's action to enjoin state from using its revised rate setting methodology for general inpatient hospital services. *New Jersey Hosp. Ass'n v. Waldman, 73 F.3d 509 (3rd Cir. N.J. 1995)*.

New Jersey Division of Medical Assistance and Health Services' calculation method for the years 1996 to 2001 with regard to determining whether hospitals had sustained a marginal loss pursuant to *N.J.A.C. 10:52-9.1(b)(2)*, as the result of providing inpatient services to Medicaid and NJ FamilyCare-Plan A recipients, properly utilized Disproportionate Share Hospitals payments. The Division's use of Medicaid costs contained in hospital Medicare cost reports in making its calculations was also upheld. *In re Hospitals' Petitions For Adjustment of Rates For Reimbursement of Inpatient Services to Medicaid Beneficiaries, 383 N.J. Super. 219, 891 A.2d 641, 2006 N.J. Super. LEXIS 42 (App.Div. 2006)*.

Remand of Medicaid rate appeal by hospitals was required, where Division of Medical Assistance failed to provide reasons for its decisions that errors in rates alleged by hospitals were not calculation errors, that requests for rate relief must be pursued under special procedure for rate appeal, and that alleged calculation errors were not substantial. *Atlantic City Med. v. Squarrell, 349 N.J.Super. 16, 793 A.2d 10 (App.Div. 2002)*.

Decision by the acting commissioner summarily rejecting hospitals' appeals seeking reimbursement of Medicaid inpatient hospital costs was arbitrary and capricious and an abdication of the responsibility under the Division of Medical Assistance and Health Services' own regulations to consider these appeals on the merits. *In re Zarbrugg Mem. Hospital, 349 N.J.Super. 27, 793 A.2d 17 (App.Div. 2002)*.

Decisions by the Division of Medical Assistance and Health Services to consider only a single issue found to be dispositive of hospitals' Medicaid rate appeals did not violate any of the statutory or regulatory provisions governing the Medicaid program or constitute an abuse of discretion. *Hospital Center at Orange v. Guhl, 331 N.J.Super. 322, 751 A.2d 1077 (App.Div. 2000)*.

Regulations promulgated by state department of human services regarding hospital rates for Medicaid patients were valid where they allowed hospitals to challenge impact of designation of labor market areas as part of rate

adjudication process. Matter of Adoption of *N.J.A.C. 10:52-5.14(d)*2 and *3, 276 N.J.Super. 568, 648 A.2d 509 (App.Div. 1994)*, certification denied *142 N.J. 448, 663 A.2d 1355*.

On the basis of *N.J.A.C. 10:52-14.6(a)*, an Administrative Law Judge (ALJ) concluded that hospitals that now were contesting the calculations, methodologies, and constitutionality of their 2013 Medicaid patient reimbursement rates may not assert a challenge in the pending proceeding based on a review of an allegedly incorrect TEFRA economic factor There was simply no cogent argument that the regulation did not re-set the base rates and re-start the clock on such determination. That finding did not, however, preclude the subsequent pass-through impact that may flow from pending judicial matters that took up review of the regulatory notice-and-comment response language in *N.J.A.C. 10:52-9.1(a)*. *AtlantiCare Reg'l Med. Ctr. et als. v. DMAHS, OAL DKT. NO. HMA 05152-2014, etc., 2015 N.J. AGEN LEXIS 184*, Initial Decision (March 30, 2015).

Initial Decision (2005 N.J. AGEN LEXIS 467) adopted, which dismissed a hospital's Medicaid rate appeal because the hospital did not submit supporting documentation within the 80-day period required by *N.J.A.C. 10:52-9.1(b)(1)(i)*, but instead waited four years to submit the documentation; under these circumstances, the hospital substantially failed to comply with the regulatory time frame. *In re Somerset Med. Ctr. & Hosp. Ctr. at Orange Petition for Review of 2000 Rates, OAL Dkt. No. HMA 8421-03 (Remand of HMA 8779-00 and HMA 9971-00), 2005 N.J. AGEN LEXIS 1113*, Final Decision (September 13, 2005).

Initial Decision (1998 N.J. AGEN LEXIS 236) adopted, which concluded that the Division of Medical Assistance and Health Services (DMAHS) properly denied hospital's request for a rate review based on hospital's failure to submit information responsive to one or more of the regulatory criteria. *In re St. Francis Med. Center (Trenton), OAL Dkt. No. HMA 2252-96, 1998 N.J. AGEN LEXIS 1108*, Final Decision (May 1, 1998).

Denial of Medicaid rates review upheld due to hospital's failure to submit sufficient information. In re: St. Mary's Hospital (Hoboken) 1995 Medicaid Rates, 97 N.J.A.R.2d (DMA) 65.

Denial of Medicaid rates review upheld due to hospital's failure to submit sufficient information. In re Palisades General Hospital, 1995 Medicaid Rates, 97 N.J.A.R.2d (DMA) 61.

Denial of Medicaid rates review upheld due to hospital's failure to submit sufficient information. In re Hackettstown Community Hospital's 1995 Medicaid Rates, 97 N.J.A.R.2d (DMA) 57.

Adjustment letter insufficient notice of Medicaid rate change reversed. In the Matter of Cathedral Healthcare System, Inc., 1994 Medicaid Rates, 97 N.J.A.R.2d (DMA) 54.

Hospital's challenge to proposed schedule of Medicaid reimbursement rate untimely if filed six months later. Saint Peter's Medical Center v. Division of Medical Assistance and Health Services, 97 N.J.A.R.2d (DMA) 51.

Hospital's rate request will be denied if it fails to show loss attributable to rendering Medicaid services while running efficient and economically-operated facility. Newcomb Medical Center v. Division of Medical Assistance and Health Services, 97 N.J.A.R.2d (DMA) 46.

Denial of Medicaid rates appeal upheld due to hospital's failure to submit sufficient information. In Re Cathedral Healthcare System, Inc., 97 N.J.A.R.2d (DMA) 27.

N.J.A.C. 10:52-10.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 10. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

§ 10:52-10.1 Introduction

(a) The New Jersey Medicaid/FamilyCare fee-for-service program utilizes the Centers for Medicare & Medicaid Services' (CMS's) Healthcare Common Procedure Coding System (HCPCS) for 2009, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, and incorporated herein by reference, as amended and supplemented, and as published by PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS (code additions, code deletions and replacement codes) will be reflected in this subchapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1* et seq. HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology architecture, employing a five position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the CMS assigned codes and modifiers contain alphabetic characters.

1. LEVEL I CODES (Narratives found in CPT)

These codes are adapted from CPT for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse Midwives, Certified Nurse Practitioners, Independent Clinics and Independent Laboratories. CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

Copyright restrictions make it impossible to print excerpts from CPT procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT, which is incorporated herein by reference, as amended and supplemented. An updated copy of the CPT (Level I) codes may be obtained from the American Medical Association, P.O. Box 10950, Chicago, IL 60610, or by accessing *www.ama-assn.org*.

2. LEVEL II CODES (Narratives found at *N.J.A.C. 10:52-10.3*)

These codes are assigned by CMS for physicians and non-physician services which are not in CPT. An updated copy of the HCPCS (Level II) codes may be obtained by accessing the HCPCS website at *http://www.cms.gov/TransactionCodeSetsStands/* or by contacting PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010.

(b) The responsibility of the provider when rendering specific services and requesting reimbursement is listed in both Subchapter 1 and Subchapter 2 of *N.J.A.C. 10:52*, Hospital Services.

(c) Regarding specific elements of HCPCS codes which requires attention of the provider, the lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code identified under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," and "MAXIMUM FEE ALLOWANCE." The information identified under each column is summarized below:

Column Title	Description

IND	(Indicator Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid/NJ FamilyCare fee-for-service program's qualifications and requirements when a procedure or service code is used. Explanation of indicators and qualifiers used in this column are identified below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. "F" preceding any procedure code indicates that this code, when used primarily for the diagnosis and treatment of infertility, is not covered by the New Jersey Medicaid/NJ FamilyCare program. "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:52-10.3. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:52-10.4.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance has been identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid/NJ FamilyCare program's recognized modifier codes are listed at N.J.A.C. 10:52-10.5.
DESCRIPTION	Lists the code narrative. (Narratives for Level I codes are found in the CPT. Narratives for Level II codes are found at N.J.A.C. 10:52-10.3.)
MAXIMUM FEE ALLOWANCE	Lists the New Jersey Medicaid/NJ FamilyCare fee-for-service program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "S.C.C." (Subject Cost-to-Charge) are listed instead of a dollar amount, it means that service is subject to the cost-to-charge ratio. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable.

1. The fee listed under "Office Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

2. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp" and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

(d) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician in

determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in CPT-4. The provider will then be liable for the additional requirements and not just the CPT/HCPCS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT-4 throughout; in (a), inserted a reference to Certified Nurse Practitioners in 1, and changed N.J.A.C. reference in 3; and in (c), inserted a reference to NJ KidCare.

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

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

In (a), substituted "Healthcare" for "Health Care Financing Administration's (HCFA)" following "program utilizes the" in the introductory paragraph and substituted "CMS" for "HCFA" throughout; substituted references to FamilyCare for references to KidCare throughout.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Rewrote the introductory paragraph of (a); in the second paragraph of (a)1 and the first paragraph of (a)2, inserted the last sentence; and deleted (a)3.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the table in (c), made grammatical and/or technical changes regarding references to Medicaid and NJ FamilyCare throughout, and in the entry for "DESCRIPTION", inserted "the", and deleted "and Level III" following "II".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-10.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 10. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance $ Prof. Comp
N	36415		$ 1.80	
	36416		$ 1.80	
	36430		$ 13.00	
	36440		$ 30.00	
	36450		$ 100.80	
	36455		$ 126.00	
	36460		$ 151.00	
	36516		$ 49.00	
	80047		$ 9.89	
N	80048		$ 9.30	
N	80050		$ 36.00	
N	80051		$ 5.90	
N	80053		$ 10.50	
N	80055		$ 15.00	
N	80061		$ 15.00	
N	80069		$ 9.60	
N	80074		$ 30.00	
N	80076		$ 7.00	
	80100		$ 5.20	
	80101		$ 5.20	
	80102		$ 15.00	
	80150		$ 15.00	
	80152		$ 15.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	80154		$ 21.50	
	80156		$ 20.00	
	80157		$ 10.00	
	80158		$ 20.00	
	80160		$ 15.00	
	80162		$ 15.00	
	80164		$ 10.00	
	80166		$ 15.00	
	80168		$ 18.00	
	80170		$ 12.60	
	80172		$ 1.80	
	80173		$ 16.10	
	80174		$ 15.00	
	80176		$ 18.00	
	80178		$ 9.00	
	80182		$ 12.00	
	80184		$ 12.80	
	80185		$ 14.65	
	80186		$ 19.00	
	80188		$ 20.00	
	80190		$ 15.00	
	80192		$ 15.00	
	80194		$ 15.00	
	80195		$ 16.03	
	80196		$ 7.00	
	80197		$ 15.00	
	80198		$ 15.00	
	80200		$ 12.60	
	80201		$ 12.00	
	80202		$ 12.00	
	80299		$ 10.80	
	80400		$ 34.00	
	80406		$ 98.00	
	80408		$ 130.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	80410		$ 102.00	
	80412		S.C.C.	
	80414		$ 61.00	
	80415		$ 50.00	
	80416		$ 150.00	
	80417		$ 50.00	
	80418		S.C.C.	
	80420		$ 74.00	
	80422		$ 45.00	
	80424		$ 33.00	
	80426		$ 130.00	
	80428		$ 60.00	
	80430		$ 73.00	
	80432		$ 125.00	
	80434		$ 100.00	
	80435		$ 95.00	
	80436		$ 75.00	
	80438		$ 50.00	
	80439		$ 74.27	
	80440		$ 60.00	
	80500		S.C.C	
	80502		S.C.C	
	81000		$ 1.20	
	81001		$ 1.20	
	81002		$ 1.00	
	81003		$ 1.50	
	81005		$ 1.00	
	81007		$ 2.84	
	81015		$ 0.40	
	81020		$ 4.30	
	81025		$ 3.00	
	81050		$ 3.40	
	81099		S.C.C	
	82000		$ 15.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	82003		$ 26.00	
	82009		$ 5.00	
	82010		$ 9.90	
	82013		$ 14.00	
	82016		$ 12.90	
	82017		$ 18.60	
	82024		$ 30.00	
	82030		$ 34.00	
A	82040		$ 1.80	
	82042		$ 2.43	
	82043		$ 4.30	
	82044		$ 1.00	
	82045		$ 39.65	
	82055		$ 4.50	
	82075		$ 8.80	
	82085		$ 11.00	
	82088		$ 40.00	
	82101		$ 16.30	
	82103		$ 7.80	
	82104		$ 7.80	
	82105		$ 10.20	
	82106		$ 10.20	
	82107		$ 75.23	
	82108		$ 28.17	
	82120		S.C.C.	
	82127		$ 12.90	
	82128		$ 12.90	
	82131		$ 18.64	
	82135		$ 20.00	
	82136		$ 18.64	
	82139		$ 18.64	
	82140		$ 6.00	
	82143		$ 4.20	
	82145		$ 12.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance $ Prof. Comp
A	82150		$ 4.50	
	82154		$ 31.88	
	82157		$ 29.00	
	82160		$ 27.65	
	82163		$ 21.00	
	82164		$ 20.00	
	82172		$ 20.00	
	82175		$ 7.20	
	82180		$ 3.60	
	82190		S.C.C.	
	82205		$ 12.00	
	82232		$ 17.80	
	82239		$ 20.00	
	82240		$ 5.69	
	82247		$ 3.00	
	82248		$ 4.50	
	82252		$ 2.50	
	82261		$ 18.64	
	82270		$ 1.20	
	82271		$ 3.80	
	82272		$ 3.80	
	82274		$ 3.70	
	82286		$ 7.60	
	82300		$ 28.00	
	82306		$ 30.00	
	82307		$ 25.00	
	82308		$ 34.00	
A	82310		$ 3.00	
	82330		$ 14.70	
	82331		$ 5.72	
	82340		$ 3.60	
	82355		$ 9.00	
	82360		$ 12.00	
	82365		$ 9.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	82370		$ 9.00	
	82373		$ 7.95	
A	82374		$ 3.30	
	82375		$ 6.00	
	82376		$ 3.00	
	82378		$ 22.40	
	82379		$ 18.64	
	82380		$ 6.00	
	82382		$ 12.00	
	82383		$ 12.00	
	82384		$ 18.00	
	82387		$ 24.00	
	82390		$ 6.00	
	82397		$ 19.50	
	82415		$ 15.00	
A	82435		$ 3.00	
	82436		$ 3.00	
	82438		$ 3.00	
	82441		$ 8.00	
A	82465		$ 3.00	
	82480		$ 4.50	
	82482		$ 10.00	
	82485		$ 28.00	
	82486		$ 4.40	
N	82487		$ 4.00	
N	82488		$ 15.00	
N	82489		$ 15.00	
	82491		$ 21.50	
	82492		$ 21.50	
	82495		$ 9.66	
	82507		$ 37.00	
	82520		$ 17.00	
	82523		$ 15.00	
	82525		$ 9.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	82528		$ 19.70	
	82530		$ 17.00	
	82533		$ 17.00	
	82540		$ 3.00	
	82541		$ 4.40	
	82542		$ 21.50	
	82543		$ 21.50	
	82544		$ 21.50	
A	82550		$ 4.80	
	82552		$ 7.80	
	82553		$ 7.50	
	82554		$ 16.00	
A	82565		$ 3.00	
	82570		$ 3.00	
	82575		$ 4.50	
	82585		$ 6.30	
	82595		$ 1.50	
	82600		$ 25.00	
	82607		$ 15.00	
	82608		$ 15.00	
	82615		$ 11.00	
	82626		$ 29.60	
	82627		$ 29.00	
	82633		$ 38.52	
	82634		$ 25.72	
	82638		$ 15.20	
	82640		$ 15.00	
	82646		$ 25.30	
	82649		$ 31.00	
	82651		$ 33.00	
	82652		$ 47.87	
	82654		$ 13.60	
	82656		$ 12.86	
	82657		$ 21.50	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	82658		$ 21.50	
	82664		$ 13.60	
	82666		$ 22.00	
	82668		$ 17.50	
	82670		$ 25.00	
	82671		$ 41.00	
	82672		$ 25.00	
	82677		$ 28.00	
	82679		$ 25.00	
	82690		$ 21.50	
	82693		$ 12.50	
	82696		$ 22.00	
	82705		$ 0.60	
	82710		$ 7.80	
	82715		$ 7.80	
	82725		$ 15.50	
	82726		$ 21.50	
N	82728		$ 16.00	
	82731		$ 71.20	
	82735		$ 24.00	
	82742		$ 21.73	
	82746		$ 10.50	
	82747		$ 18.00	
	82757		$ 22.50	
	82759		$ 11.50	
	82760		$ 15.00	
	82775		$ 3.74	
	82776		$ 8.90	
	82784		$ 11.30	
	82785		$ 16.00	
	82787		$ 11.09	
	82800		$ 5.20	
	82803		$ 16.50	
	82805		$ 8.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	82810		$ 10.00	
	82820		$ 13.82	
	82926		$ 6.00	
	82928		$ 6.00	
	82938		$ 22.00	
	82941		$ 16.00	
	82943		$ 19.00	
	82945		$ 4.34	
	82946		$ 13.00	
A	82947		$ 4.34	
	82948		$ 1.50	
	82950		$ 3.00	
	82951		$ 5.00	
	82952		$ 1.00	
	82953		$ 10.00	
	82955		$ 6.00	
	82960		$ 7.00	
	82962		$ 2.60	
	82963		$ 26.50	
	82965		$ 6.30	
	82975		$ 19.80	
A	82977		$ 4.80	
	82978		$ 12.00	
	82979		$ 9.00	
	82980		$ 20.00	
	82985		$ 6.60	
	83001		$ 17.00	
	83002		$ 17.00	
	83003		$ 16.00	
	83004		$ 16.00	
	83008		$ 21.60	
	83009		$ 50.71	
	83010		$ 12.00	
	83012		$ 12.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	83013		$ 48.00	
	83014		$ 9.00	
	83015		$ 10.20	
	83018		$ 25.00	
	83020		$ 6.00	
	83021		$ 21.50	
	83026		$ 2.00	
	83030		$ 10.00	
	83033		$ 7.00	
	83036		$ 6.60	
	83045		$ 1.50	
	83050		$ 3.00	
	83051		$ 1.20	
	83055		$ 1.50	
	83060		$ 3.00	
	83065		$ 3.00	
	83068		$ 3.00	
	83069		$ 3.00	
	83070		$ 6.00	
	83071		$ 9.00	
	83080		$ 19.20	
	83088		$ 40.00	
	83090		$ 18.65	
	83150		$ 12.00	
	83256		$ 10.00	
	83491		$ 12.60	
	83497		$ 6.00	
	83498		$ 30.50	
	83499		$ 30.50	
	83500		$ 30.00	
	83505		$ 30.00	
	83516		$ 9.00	
	83518		$ 8.00	
	83519		$ 15.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	83520		S.C.C.	
	83525		$ 12.00	
	83527		$ 16.11	
	83528		$ 20.00	
A	83540		$ 4.50	
A	83550		$ 7.20	
	83570		$ 6.00	
	83582		$ 6.00	
	83586		$ 7.50	
	83593		$ 6.00	
	83605		$ 13.50	
A	83615		$ 4.20	
	83625		$ 9.00	
	83630		$ 22.93	
	83631		$ 22.93	
	83632		$ 16.00	
	83633		$ 6.30	
	83634		$ 14.00	
N	83655		$ 9.00	
	83661		$ 10.50	
	83662		$ 5.00	
	83663		$ 10.46	
	83664		$ 5.23	
	83670		$ 2.10	
	83690		$ 4.50	
	83695		$ 15.13	
	83698		$ 39.65	
	83700		$ 13.15	
	83701		$ 28.99	
	83704		$ 36.86	
	83715		$ 7.50	
A	83718		$ 8.00	
	83719		$ 15.50	
	83721		$ 10.66	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	83727		$ 17.00	
A	83735		$ 4.50	
	83775		$ 5.90	
	83785		$ 12.99	
	83788		$ 4.40	
	83789		$ 4.40	
	83805		$ 23.00	
	83825		$ 8.40	
	83835		$ 10.20	
	83840		$ 4.50	
	83857		$ 12.00	
	83858		$ 19.80	
	83864		$ 13.00	
	83866		$ 12.00	
	83872		$ 3.20	
	83873		$ 20.00	
	83874		$ 12.00	
	83876		$ 15.13	
	83880		$ 37.94	
	83883		S.C.C.	
	83885		$ 19.00	
	83887		$ 20.00	
	83890		$ 5.00	
	83891		$ 5.00	
	83892		$ 5.00	
	83893		$ 5.00	
	83894		$ 5.00	
	83896		$ 5.00	
	83897		$ 5.00	
	83898		$ 20.00	
	83900		$ 39.16	
	83901		$ 20.00	
	83902		$ 19.00	
	83903		$ 20.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	83904		$ 20.00	
	83905		$ 20.00	
	83906		$ 20.00	
	83907		$ 15.60	
	83908		$ 19.58	
	83909		$ 19.58	
	83912		$ 5.54	
	83913		$ 15.60	
	83914		$ 19.58	
	83915		$ 6.00	
	83916		$ 20.00	
	83918		$ 19.00	
	83919		$ 19.00	
	83921		$ 19.00	
	83925		$ 22.00	
	83930		$ 9.00	
	83935		$ 9.00	
	83937		$ 40.00	
	83945		$ 17.00	
	83950		$ 71.20	
	83951		$ 75.23	
	83970		$ 54.00	
	83986		$ 4.30	
	83992		$ 18.00	
	84022		$ 22.93	
	84030		$ 6.00	
	84035		$ 4.90	
	84060		$ 3.60	
	84061		$ 3.60	
	84066		$ 12.60	
A	84075		$ 3.60	
	84078		$ 3.60	
	84080		$ 3.60	
N	84081		$ 20.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance $ Prof. Comp
	84085		$ 7.90	
	84087		$ 13.50	
A	84100		$ 3.00	
	84105		$ 3.00	
	84106		$ 1.80	
	84110		$ 7.50	
	84119		$ 3.00	
	84120		$ 7.50	
	84126		$ 34.50	
	84127		$ 15.00	
A	84132		$ 3.90	
	84133		$ 3.90	
	84134		$ 20.00	
	84135		$ 12.00	
	84138		$ 12.00	
	84140		$ 27.50	
	84143		$ 30.00	
	84144		$ 20.00	
	84146		$ 20.00	
	84150		$ 30.00	
	84152		$ 24.50	
A	84153		$ 24.50	
	84154		$ 24.50	
	84155		$ 1.80	
	84156		$ 1.80	
	84157		$ 1.80	
	84160		$ 1.80	
	84163		$ 17.58	
	84165		$ 6.00	
	84166		$ 20.83	
	84181		$ 20.00	
	84182		$ 23.50	
N	84202		$ 10.40	
N	84203		$ 3.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	84206		$ 19.00	
	84207		$ 32.00	
	84210		$ 12.80	
	84220		$ 13.00	
	84228		$ 13.60	
	84233		$ 16.00	
	84234		$ 20.00	
	84235		$ 63.20	
	84238		$ 43.00	
	84244		$ 25.00	
	84252		$ 24.00	
	84255		$ 29.60	
	84260		$ 35.20	
	84270		$ 25.00	
	84275		$ 16.00	
	84285		$ 28.80	
A	84295		$ 3.90	
	84300		$ 3.90	
	84302		$ 3.90	
	84305		$ 16.00	
	84307		$ 16.00	
	84311		$ 7.50	
	84315		$ 3.00	
	84375		$ 23.20	
	84376		$ 7.00	
	84377		$ 7.00	
	84378		$ 14.00	
	84379		$ 14.00	
	84392		$ 5.60	
	84402		$ 30.40	
	84403		$ 32.00	
	84425		$ 29.00	
	84430		$ 3.60	
	84432		$ 13.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	84436		$ 6.00	
	84437		$ 6.00	
	84439		$ 10.00	
	84442		$ 12.00	
	84443		$ 23.00	
	84445		$ 27.80	
	84446		$ 16.80	
	84449		$ 24.00	
A	84450		$ 3.00	
A	84460		$ 3.00	
	84466		$ 15.20	
A	84478		$ 7.30	
	84479		$ 6.00	
	84480		$ 15.00	
	84481		$ 15.00	
	84482		$ 15.00	
	84484		$ 12.00	
	84485		$ 3.30	
	84488		$ 3.30	
	84490		$ 3.30	
	84510		$ 12.70	
	84512		S.C.C.	
A	84520		$ 3.00	
	84525		$ 3.00	
	84540		$ 3.00	
	84545		$ 6.00	
A	84550		$ 3.00	
	84560		$ 3.00	
	84577		$ 6.00	
	84578		$ 0.40	
	84580		$ 2.10	
	84583		$ 2.10	
	84585		$ 12.00	
	84586		$ 48.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	84588		$ 45.00	
	84590		$ 6.00	
	84591		$ 12.82	
	84597		$ 18.00	
	84600		$ 18.00	
N	84620		$ 16.00	
	84630		$ 15.00	
	84681		$ 22.00	
	84702		$ 11.39	
	84703		$ 3.00	
	84704		$ 17.58	
	84830		$ 3.00	
	84999		S.C.C.	
	85002		$ 1.20	
	85004		$ 7.20	
N	85007		$ 2.40	
	85008		$ 1.20	
	85009		$ 1.20	
	85013		$ 1.50	
N	85014		$ 1.50	
N	85018		$ 1.20	
N	85025		S.C.C.	
N	85027		$ 4.80	
	85032		$ 3.00	
N	85041		$ 1.20	
	85044		$ 3.00	
	85045		$ 4.00	
	85046		$ 2.75	
N	85048		$ 1.20	
N	85049		$ 5.00	
	85055		$ 29.93	
	85060		S.C.C.	
	85097		S.C.C.	
	85130		S.C.C.	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	85170		$ 0.60	
	85175		$ 3.90	
	85210		$ 3.00	
	85220		$ 24.00	
	85230		$ 24.00	
	85240		$ 24.00	
	85244		$ 28.00	
	85245		$ 10.00	
	85246		$ 10.00	
	85247		$ 10.00	
	85250		$ 26.00	
	85260		$ 24.00	
	85270		$ 24.00	
	85280		$ 26.00	
	85290		$ 8.00	
	85291		$ 7.00	
	85292		$ 26.00	
	85293		$ 26.00	
	85300		$ 15.00	
	85301		$ 14.00	
	85302		$ 16.00	
	85303		$ 18.00	
	85305		$ 16.00	
	85306		$ 18.00	
	85307		$ 18.00	
	85335		$ 10.00	
	85337		$ 10.00	
	85345		$ 1.80	
	85347		$ 3.00	
	85348		$ 1.20	
	85360		$ 11.00	
	85362		$ 3.00	
	85366		$ 8.00	
	85370		$ 5.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	85378		$ 5.00	
	85379		$ 5.00	
	85380		$ 5.00	
	85384		$ 9.60	
	85385		$ 9.60	
	85390		$ 7.00	
	85396		$ 18.00	
	85397		$ 26.81	
	85400		$ 9.00	
	85410		$ 9.00	
	85415		$ 10.00	
	85420		$ 9.00	
	85421		$ 14.00	
	85441		$ 5.00	
	85445		$ 5.00	
	85460		$ 9.40	
	85461		$ 9.00	
	85475		$ 10.00	
	85520		$ 7.97	
	85525		$ 16.00	
	85530		$ 16.00	
	85536		$ 5.00	
	85540		$ 8.90	
	85547		$ 10.50	
	85549		$ 25.00	
	85555		$ 4.80	
	85557		$ 4.80	
	85576		$ 24.01	
	85597		$ 20.00	
	85610		$ 3.00	
	85611		$ 4.50	
	85612		$ 13.00	
	85613		$ 10.00	
	85635		$ 8.40	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	85651		$ 1.50	
	85652		$ 1.50	
	85660		$ 3.00	
	85670		$ 8.00	
	85675		$ 6.00	
	85705		$ 7.90	
	85730		$ 3.00	
	85732		$ 3.00	
	85810		$ 15.00	
	85999		S.C.C.	
	86000		$ 0.90	
	86001		$ 4.00	
	86003		$ 4.00	
	86005		$ 3.24	
	86021		$ 9.00	
	86022		$ 9.00	
	86023		$ 15.00	
	86038		$ 7.80	
	86039		$ 15.00	
	86060		$ 3.60	
	86063		$ 1.20	
	86077		S.C.C.	
	86078		S.C.C.	
	86079		S.C.C.	
	86140		$ 3.00	
	86141		$ 14.30	
	86146		$ 35.00	
	86147		$ 35.00	
	86148		$ 22.00	
	86155		$ 14.00	
	86156		$ 3.00	
	86157		$ 9.00	
	86160		$ 9.00	
	86161		$ 9.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	86162		$ 15.60	
	86171		$ 4.50	
	86185		$ 7.90	
	86200		$ 15.13	
	86215		$ 18.00	
	86225		$ 13.00	
	86226		$ 15.00	
	86235		$ 24.00	
	86243		$ 15.90	
	86255		$ 7.80	
	86256		$ 12.50	
	86277		$ 16.00	
	86280		$ 5.40	
	86294		$ 12.00	
	86300		$ 23.00	
	86301		$ 23.00	
	86304		$ 23.00	
	86308		$ 3.00	
	86309		$ 5.00	
	86310		$ 4.50	
	86316		$ 28.00	
	86317		$ 8.00	
	86318		$ 7.00	
	86320		$ 10.50	
	86325		$ 25.00	
	86327		$ 25.00	
	86329		$ 19.00	
	86331		$ 4.50	
	86332		$ 33.00	
	86334		$ 30.00	
	86335		$ 34.28	
	86336		S.C.C.	
	86337		$ 13.71	
	86340		$ 20.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	86341		$ 25.00	
	86343		$ 6.00	
	86344		$ 10.86	
	86353		$ 32.00	EACH MITOGEN
	86355		$ 44.06	
	86356		$ 31.27	
	86357		$ 44.06	
	86359		$ 40.00	
	86360		$ 55.00	
	86361		$ 55.00	
	86367		$ 44.06	
	86376		$ 6.60	
	86378		$ 26.00	
	86382		$ 20.00	
	86384		$ 10.86	
	86403		$ 8.00	
	86406		$ 6.60	
	86430		$ 1.80	
	86431		$ 4.50	
	86480		$ 72.39	
	86485		S.C.C.	
	86486		$ 4.54	
	86490		S.C.C.	
	86510		S.C.C.	
	86580		S.C.C.	
	86590		$ 8.00	
	86592		$ 1.50	
	86593		$ 3.00	
	86602		$ 10.00	
	86603		$ 10.00	
	86606		$ 10.00	
	86609		$ 10.00	
	86611		$ 11.20	
	86612		$ 10.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	86615		$ 10.00	
	86617		$ 19.00	
	86618		$ 23.00	
	86619		$ 10.00	
	86622		$ 8.00	
	86625		$ 10.00	
	86628		$ 10.00	
	86631		$ 10.00	
	86632		$ 15.00	
	86635		$ 10.00	
	86638		$ 12.50	
	86641		$ 12.50	
	86644		$ 12.00	
	86645		$ 12.00	
	86648		$ 18.00	
	86651		$ 12.00	
	86652		$ 12.00	
	86653		$ 12.00	
	86654		$ 12.00	
	86658		$ 12.00	
	86663		$ 12.00	
	86664		$ 21.00	
	86665		$ 25.00	
	86666		$ 11.20	
	86668		$ 12.00	
	86671		$ 15.00	
	86674		S.C.C.	
	86677		$ 12.00	
	86682		$ 12.00	
	86684		$ 15.00	
	86687		$ 11.60	
	86688		$ 13.00	
	86689		$ 21.20	
	86692		$ 20.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	86694		$ 12.80	
	86695		$ 12.80	
	86696		$ 21.40	
	86698		$ 15.00	
	86701		$ 12.00	
	86702		$ 13.00	
	86703		$ 18.00	
	86704		$ 15.00	
	86705		$ 12.60	
	86706		$ 12.00	
	86707		$ 12.00	
	86708		$ 12.00	
	86709		$ 12.60	
	86710		$ 12.00	
	86713		$ 20.00	
	86717		S.C.C.	
	86720		$ 15.00	
	86723		$ 15.00	
	86727		$ 15.00	
	86729		$ 12.00	
	86732		$ 15.00	
	86735		$ 15.00	
	86738		$ 12.00	
	86741		$ 12.00	
	86744		$ 12.00	
	86747		$ 12.00	
	86750		$ 12.00	
	86753		$ 12.00	
	86756		$ 12.00	
	86757		$ 21.40	
	86759		$ 12.00	
	86762		$ 12.00	
	86765		$ 10.00	
	86768		$ 12.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	86771		$ 12.00	
	86774		$ 5.40	
	86777		$ 12.00	
	86778		$ 15.00	
	86781		$ 12.00	
	86784		$ 8.00	
	86787		$ 12.60	
	86788		$ 19.68	
	86789		$ 16.82	
	86790		S.C.C.	
	86793		$ 8.00	
	86800		$ 13.00	
	86803		$ 19.00	
	86804		$ 20.00	
	86805		$ 22.00	
	86806		$ 22.00	
	86807		$ 54.00	
	86808		$ 39.00	
	86812		$ 12.60	
	86813		$ 19.00	
	86816		$ 19.00	
	86817		$ 19.00	
	86821		$ 68.00	
	86822		$ 50.00	
	86849		S.C.C.	
	86850		S.C.C.	
	86860		S.C.C.	
	86870		S.C.C.	
	86880		$ 5.00	
	86885		$ 6.80	
	86886		$ 5.00	
	86890		$ 75.00	
	86891		$ 75.00	
	86900		S.C.C.	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	86901		S.C.C.	
	86903		S.C.C.	
	86904		S.C.C.	
	86905		$ 3.00	
	86906		$ 2.00	
	86910		$ 12.60	
	86911		$ 5.00	
	86920		S.C.C.	
	86921		S.C.C.	
	86922		S.C.C.	
	86940		$ 9.50	
	86941		$ 12.50	
	86945		S.C.C.	
	86950		S.C.C.	
	86960		$ 25.00	
	86965		S.C.C.	
	86970		S.C.C.	
	86971		S.C.C.	
	86972		S.C.C.	
	86975		S.C.C.	
	86976		S.C.C.	
	86977		S.C.C.	
	86978		S.C.C.	
	86985		S.C.C.	
	86999		S.C.C.	
	87001		$ 9.00	
	87003		$ 15.00	
	87015		$ 5.10	
N	87040		$ 9.00	
N	87045		$ 9.00	
N	87046		$ 3.00	
N	87070		$ 9.00	
	87071		$ 6.00	
	87073		$ 6.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	87075		$ 9.00	
	87076		$ 6.00	
	87077		$ 9.00	
N	87081		$ 9.00	
	87084		$ 3.00	
	87086		$ 6.00	
	87088		$ 2.70	
	87101		$ 8.00	
	87102		$ 8.00	
	87103		$ 8.00	
	87106		$ 8.00	
	87107		$ 11.42	
	87109		$ 14.00	
	87110		$ 15.00	
	87116		$ 6.00	
	87118		$ 12.00	
	87140		$ 3.00	
	87143		$ 3.00	
	87147		$ 3.00	
	87149		$ 22.00	
	87152		$ 5.79	
	87158		$ 3.00	
	87164		$ 6.00	
	87166		$ 6.00	
	87168		$ 4.72	
	87169		$ 4.72	
	87172		$ 4.72	
	87176		$ 6.40	
	87177		$ 5.10	
	87181		$ 5.80	
N	87184		$ 9.00	
	87185		$ 5.25	
	87186		$ 11.00	
	87187		$ 13.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	87188		$ 6.00	
	87190		$ 0.60	
	87197		$ 15.00	
	87205		$ 4.20	
	87206		$ 4.20	
	87207		$ 3.00	
	87209		$ 20.99	
	87210		$ 2.40	
	87220		$ 2.40	
	87230		$ 27.00	
	87250		$ 25.50	
	87252		$ 29.50	
	87253		$ 6.00	
	87254		$ 5.41	
	87255		$ 30.00	
	87260		$ 10.00	
	87265		$ 10.00	
	87267		$ 10.00	
	87269		$ 10.00	
	87270		$ 10.00	
	87271		$ 10.00	
	87272		$ 12.00	
	87273		$ 12.18	
	87274		$ 12.80	
	87275		$ 12.18	
	87276		$ 12.00	
	87277		$ 12.18	
	87278		$ 15.00	
	87279		$ 12.18	
	87280		$ 12.00	
	87281		$ 12.18	
	87283		$ 12.18	
	87285		$ 12.00	
	87290		$ 12.60	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	87299		$ 12.00	
	87300		$ 6.00	
	87301		$ 12.00	
	87305		$ 12.86	
	87320		$ 12.50	
	87324		$ 12.50	
	87327		$ 12.18	
	87328		$ 12.50	
	87329		$ 12.00	
	87332		$ 12.00	
	87335		$ 12.00	
	87336		$ 12.18	
	87337		$ 12.18	
	87338		S.C.C.	
	87339		$ 12.18	
	87340		$ 14.00	
	87341		$ 11.42	
	87350		$ 14.00	
	87380		$ 20.00	
	87385		$ 15.00	
	87390		$ 15.00	
	87391		$ 15.00	
	87400		$ 6.00	
	87420		$ 12.00	
	87425		$ 12.00	
	87427		$ 12.18	
	87430		$ 12.00	
	87449		$ 12.00	
	87450		$ 10.00	
	87451		$ 10.60	
	87470		$ 20.00	
	87471		$ 30.00	
	87472		$ 20.00	
	87475		$ 25.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	87476		$ 38.00	
	87477		$ 20.00	
	87480		$ 25.00	
	87481		$ 38.00	
	87482		$ 20.00	
	87485		$ 25.00	
	87486		$ 38.00	
	87487		$ 20.00	
	87490		$ 20.00	
	87491		$ 38.00	
	87492		$ 20.00	
	87495		$ 25.00	
	87496		$ 38.00	
	87497		$ 20.00	
	87498		$ 41.00	
	87500		$ 41.00	
	87510		$ 25.00	
	87511		$ 28.00	
	87512		$ 20.00	
	87515		$ 25.00	
	87516		$ 38.00	
	87517		$ 20.00	
	87520		$ 25.00	
	87521		$ 38.00	
	87522		$ 20.00	
	87525		$ 25.00	
	87526		$ 38.00	
	87527		$ 20.00	
	87528		$ 25.00	
	87529		$ 38.00	
	87530		$ 20.00	
	87531		$ 25.00	
	87532		$ 38.00	
	87533		$ 20.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	87534		$ 25.00	
	87535		$ 38.00	
	87536		$ 117.00	
	87537		$ 25.00	
	87538		$ 38.00	
	87539		$ 20.00	
	87540		$ 25.00	
	87541		$ 38.00	
	87542		$ 20.00	
	87550		$ 25.00	
	87551		$ 38.00	
	87552		$ 20.00	
	87555		$ 25.00	
	87556		$ 38.00	
	87557		$ 20.00	
	87560		$ 25.00	
	87561		$ 38.00	
	87562		$ 20.00	
	87580		$ 25.00	
	87581		$ 38.00	
	87582		$ 20.00	
	87590		$ 25.00	
	87591		$ 38.00	
	87592		$ 20.00	
	87620		$ 25.00	
	87621		$ 38.00	
	87622		$ 20.00	
	87640		$ 41.00	
	87641		$ 41.00	
	87650		$ 25.00	
	87651		$ 38.00	
	87652		$ 20.00	
	87653		$ 41.00	
	87660		$ 25.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	87797		$ 25.00	
	87798		$ 38.00	
	87799		$ 20.00	
	87800		$ 25.00	
	87801		$ 38.00	
	87802		$ 12.17	
	87803		$ 12.17	
	87804		$ 12.17	
	87807		$ 12.86	
	87808		$ 12.86	
	87809		$ 12.86	
	87810		$ 12.00	
	87850		$ 12.00	
	87880		$ 12.00	
	87899		$ 12.00	
	87900		$ 152.25	
	87901		$ 289.75	
	87902		$ 287.75	
	87903		$ 546.18	
	87904		$ 36.00	
	87905		$ 14.27	
	87999		S.C.C.	
	88104		S.C.C.	
	88106		S.C.C.	
	88107		S.C.C.	
	88108		S.C.C.	
	88112		$ 18.00	
	88125		S.C.C.	
	88130		$ 9.65	
	88140		$ 4.20	
	88141		$ 6.00	
	88142		$ 18.00	
	88143		$ 18.00	
	88147		$ 13.48	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	88148		$ 13.48	
	88150		$ 6.00	
	88152		$ 6.00	
	88153		$ 6.00	
	88154		$ 6.00	
N	88155		$ 6.00	
	88160		S.C.C.	
	88161		S.C.C.	
	88162		S.C.C.	
	88164		$ 6.00	
	88165		$ 6.00	
	88166		$ 6.00	
	88167		$ 6.00	
	88172		S.C.C.	
	88173		S.C.C.	
	88174		$ 23.50	
	88175		$ 28.50	
	88182		$ 300.00	
	88184		$ 70.50	
	88185		$ 41.90	
	88187		$ 54.53	
	88188		$ 67.05	
	88189		$ 85.24	
	88199		S.C.C.	
	88230		$ 90.00	
	88233		$ 90.00	
	88235		$ 90.00	
	88237		$ 90.00	
	88239		$ 90.00	
	88240		$ 7.75	
	88241		$ 7.75	
	88245		$ 184.00	
	88248		$ 230.00	
	88249		$ 230.00	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	88262		$ 172.00	
	88263		$ 184.00	
	88264		$ 172.00	
	88267		$ 230.00	
	88271		$ 16.00	
	88273		$ 35.00	
	88274		$ 45.00	
	88275		$ 55.00	
	88280		$ 34.00	
	88283		$ 46.00	
	88285		$ 27.23	
	88289		$ 40.00	
	88291		$ 26.82	
	88299		S.C.C.	
	88300		S.C.C.	
	88302		S.C.C.	
	88304		S.C.C.	
	88305		S.C.C.	
	88307		S.C.C.	
	88309		S.C.C.	
	88311		S.C.C.	
	88312		S.C.C.	
	88313		S.C.C.	
	88314		S.C.C.	
	88318		S.C.C.	
	88319		S.C.C.	
	88321		S.C.C.	
	88323		S.C.C.	
	88325		S.C.C.	
	88329		S.C.C.	
	88331		S.C.C.	
	88332		S.C.C.	
	88333		$ 78.94	
	88334		$ 47.60	

§ 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance
				$ Prof. Comp
	88342		S.C.C.	
	88346		$ 40.00	
	88347		$ 45.00	
N	88348		$ 184.00	
N	88349		S.C.C.	
	88355		S.C.C.	
	88356		S.C.C.	
	88358		S.C.C.	
	88360		$ 104.20	
	88361		$ 94.00	
	88362		S.C.C.	
	88365		$ 47.25	
	88367		$ 210.59	
	88368		$ 184.68	
	88371		$ 30.00	
	88372		S.C.C.	
	88380		S.C.C.	
	88381		$ 187.82	
	88384		$ 256.00	
	88385		$ 462.87	
	88386		$ 592.86	
	88399		S.C.C.	
	88720		$ 5.86	
	88740		$ 5.86	
	88741		$ 5.86	
	89049		$ 208.74	
	89050		$ 0.90	
	89051		$ 0.90	
	89055		$ 4.76	
	89060		$ 8.50	
	89100		S.C.C.	
	89105		S.C.C.	
	89125		$ 0.60	
	89130		S.C.C.	

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance $ Prof. Comp
	89132		S.C.C.	
	89135		S.C.C.	
	89136		S.C.C.	
	89140		S.C.C.	
	89141		S.C.C.	
	89160		$ 2.10	
	89190		$ 2.20	
	89205		$ 1.20	
	89220		$ 8.00	
	89225		$ 4.50	
	89230		$ 4.32	
	89310		$ 4.80	
	89320		$ 9.00	
	89321		$ 9.00	
	89325		$ 13.00	
	89331		$ 22.88	

History

HISTORY:

Amended by R.2002 d.323, effective October 7, 2002.

See: *34 N.J.R. 959(a)*, *34 N.J.R. 3524(a)*.

Added HCPCS Code 82731 and its corresponding Office Total Fee.

Amended by R.2003 d.15, effective January 6, 2003.

See: *34 N.J.R. 2676(a)*, *35 N.J.R. 230(c)*.

Updated the table of HCPCS procedure codes.

Repeal and New Rule, R.2005 d.214, effective July 5, 2005.

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

Section was "HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory".

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Rewrote the table.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-10.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 10. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

§ 10:52-10.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT)

PATHOLOGY/LABORATORY

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
	G0027		Semen analysis; presence and/or motility of sperm excluding Huhner test	2.40
	G0123		Screening cytopathology, cervical or vaginal, thin prep, auto	23.50
	G0141		Screening cytopathology smears, cervical or vaginal performed by automated system, with manual rescreening requiring interpretation by physician	10.00
	G0306		Complete CBC, automated (HGB, HCT, RBC, WBC, without platelet count) and automated WBC differential count	5.00
	G0307		Complete CBC, automated (HGB, HCT, RBC, WBC, without platelet count)	4.80
	G0328		Colorectal cancer screening; fecal-occult blood	7.00

PATHOLOGY/LABORATORY

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
			test, immunoassay, 1-3 simultaneous determinations	
	J0886		Injection, Epoetin Alpha, 1000 units (for ESRD patients on dialysis)	13.31
	P3000		Screening Papanicolaou smear, cervical or vaginal, up to three smears; by technician under physician supervision	6.00
	P3001		Requiring interpretation by physician	6.00
	P9010		Blood transfusion, whole blood (per unit)	S.C.C.
	P9011		Blood transfusion, split unit, (specify amount)	S.C.C.
	P9012		Cryopreipitate, each unit	S.C.C.
	P9016		Leukocyte poor blood, each unit	S.C.C.
	P9017		Fresh frozen plasma, single	S.C.C.
	P9019		Platelets, each unit	S.C.C.
	P9020		Platelet rich plasma, each unit	S.C.C.
	P9021		Red blood cells, each unit	S.C.C.
	P9022		Red blood cells, washed, each unit	S.C.C.
	P9023		Plasma, pooled multiple, donor solvent/detergent treated, frozen, each unit	S.C.C.
	P9031		Platelets, leukocytes reduced, each unit	S.C.C.

PATHOLOGY/LABORATORY

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
	P9032		Platelets, irradiated, each unit	S.C.C.
	P9033		Platelets, leukocytes reduced, irradiated, each unit	S.C.C.
	P9034		Platelets, pheresis, each unit	S.C.C.
	P9035		Platelets, pheresis, leukocytes reduced, each unit	S.C.C.
	P9036		Platelets, pheresis, irradiated, each unit	S.C.C.
	P9037		Platelets, pheresis, leukocytes reduced, irradiated, each unit	S.C.C.
	P9038		Red blood cells, irradiated, each unit	S.C.C.
	P9039		Red blood cells, deglycerolized, each unit	S.C.C.
	P9040		Red blood cells, leukocytes reduced, irradiated, each unit	S.C.C.
	P9041		Infusion, albumin (human), 5%, 50ml	S.C.C.
	P9043		Infusion, plasma protein fraction (human), 5%, 50ml	S.C.C.
	P9044		Plasma, cryoprecipitate reduced, each unit	S.C.C.
	P9045		Infusion, albumin (human), 5%, 250 ml	S.C.C.
	P9046		Infusion, albumin (human), 25%, 20ml	S.C.C.
	P9047		Infusion, albumin (human)	S.C.C.

PATHOLOGY/LABORATORY

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
			25%, 50ml	
	P9051		Whole blood or red blood cells, leukocytes reduced, cmv-negative, each unit	S.C.C.
	P9052		Platelets, hla-matched leukocytes reduced, apheresis/pheresis, each unit	S.C.C.
	P9053		Platelets, pheresis, leukocytes, reduced, cmv-negative, irradiated each unit	S.C.C.
	P9056		Whole blood, leukocytes reduced, irradiated, each unit	S.C.C.
	P9058		Red blood cells, leukocytes reduced, each unit	S.C.C.
	P9060		Fresh frozen plasma, donor retested, each unit	S.C.C.
	P9604		Prorated trip charge	1.38
	P9612		Catheterization for collection of urine; all places of service	1.80
	P9615		Catheterization for collection of (urine) specimen(s), (multiple) patients QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless	1.80

PATHOLOGY/LABORATORY

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
			of the number of patient encounters per day.	
	Q0111		Wet mount, including preparations of vaginal, cervical or skin specimens	2.40
	Q0112		All potassium hydroxide (KOH) preparations	2.40
	Q0113		Pinworm examination	5.10
	Q0114		Fern test	9.60
	Q0115		Post-coital direct, qualitative examinations of vaginal or cervical mucous	12.33
	Q4081		Injection, epoetin alfa, 100 units (for ESRD on dialysis)	1.33

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In the table, deleted a reference to home bound, nursing and SNF patients in P9610, and deleted W8900, W8920 and W8925.

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

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

Added HCPCS codes G0027, G0141, G0306, G0307, G0328, P3000, P3001, P9031 through P9034, P9040, P9041, P9043, P9044, P9046, P9604, P9612 and W8900; deleted HCPCS codes G0001, P9610, Q0116, W8200, W8260, W8265, and W8730.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Rewrote the table.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-10.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 10. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

§ 10:52-10.4 Pathology and Laboratory HCPCS Codes--Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Organ or Disease Oriented Laboratory Panels

NOTE: The following calculations and ratios are not eligible for separate or additional reimbursement.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

2. Codes 80048, 80050, 80051, 80053, 80055, 80061, 80069, 80074, and 80076. The panels listed must include the laboratory tests assigned by the CPT as the components of the panel. The tests listed with each of the panels identify the defined components of that panel. If any laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid/NJ FamilyCare fee-for-service program more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

3. Codes 82487, 82488, and 82489--Chromatography--must list substance (compound) tested for in block 34 (REMARKS) of the claim form.

4. Code 84202--Protoporphyrin, RBC; quantitative--Utilize only for testing of anemia. Utilize code 84203--Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will no longer be reimbursed when billed in conjunction with code 83655--Blood lead determination (quantitative).

5. Code 84620--Xylose absorption tests, blood and/or urine (D-xylose tolerance test), includes serum & urine levels, up to 5 hourly specimens.

6. Codes 85025 and 85027--Hematology

NOTE: For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a hematocrit, hemoglobin determination, RBC count, RBC indices, WBC count and differential WBC count.

Hematology codes 85014, 85018, 85041 and 85048 may not be reimbursed in conjunction with codes for blood count with hemogram (85025, and 85027).

The code for manual differential WBC count (85007) may not be reimbursed in conjunction with codes 85025, and 85027.

Codes for platelet count 85049 may not be reimbursed in conjunction with codes 85025 and 85027.

7. Codes 87040, 87045, 87070, 87184--Cultures

NOTE: These codes may only be reimbursed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture; (87081).

8. Code 88155--Pap smear

NOTE: Obtaining specimen not a separate eligible service.

9. Code 88348 and 88349--Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

NOTE: For reimbursement purposes, the Medicaid/NJ FamilyCare fee-for-service programs will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, that is, gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

10. Code 36415--Utilize this code only for finger/heel/ear stick for collection of specimen(s). This service is reimbursable in the physician office laboratory (POL) when the specimen is referred out to an independent clinical laboratory for testing. Finger/heel/ear stick is not reimbursable when billed by the independent clinical laboratory.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), inserted references to NJ KidCare fee-for-service programs in 2 and 11, and substituted a reference to CPT for a reference to CPT-4 in 2.

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

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

Rewrote the section.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

Deleted (a)11.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a)2, inserted a comma following "80074", and substituted "Medicaid/NJ" for "Medicaid or NJ"; and in the note following (a)9, substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-10.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 10. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

§ 10:52-10.5 Pathology and Laboratory HCPCS Codes--Modifiers

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance has been identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid/NJ FamilyCare fee-for-service programs' recognized modifier codes are:

Modifier Code	Description
22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. A report may also be appropriate.
26	Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), inserted a reference to NJ KidCare fee-for-service programs.

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

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

In (a), substituted "FamilyCare" for "KidCare" in the introductory paragraph.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a), substituted "Medicaid/NJ" for "Medicaid and NJ".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-11.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.1 Charity care audit functions

(a) The Department of Health shall conduct an audit of disproportionate share hospitals' charity care reported as written-off each calendar year. The Department of Health shall audit charity care at least once, but no more than six times each calendar year.

(b) The Department of Health shall report to the Division of Medical Assistance and Health Services on charity care. This report shall include any adjustments made pursuant to *N.J.A.C. 10:52-11.15* or *13.4* or approvals made pursuant to *N.J.A.C. 10:52-11.8(c)* and (d).

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (b), substituted "report to the Division of Medical Assistance and Health Services" for "make a monthly report to the Essential Health Services Commission" in the first sentence, and changed N.J.A.C. references in the second sentence.

Amended by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

In (a), substituted "disproportionate share" for "acute care" preceding "hospitals' charity"; in (b), amended N.J.A.C. references.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted "and Senior Services" following "Health" throughout.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.2 Sampling methodology

(a) The Department of Health shall audit charity care claims based on a sample which will be developed from the charity claims submitted for pricing as described in *N.J.A.C. 10:52-12.2*.

(b) The Department of Health shall require hospitals to make a small number of additional charity care accounts available upon audit.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote (a); and deleted a former (c).

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a) and (b), deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-11.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.3 Charity care write off amount

(a) The Department of Health shall value charity care claims at the Medicaid/NJ FamilyCare rate. The Medicaid/NJ FamilyCare rate, for purposes of valuing a given charity care claim, shall be based on the New Jersey Medicaid/NJ FamilyCare program's pricing and program policies pursuant to *N.J.A.C. 10:52-12.1* and *12.2*. For write-off and billing purposes, the hospital shall use the following procedures:

1. Charity Care Write-Off Amount equals Charity Care Eligibility Percentage, as determined by *N.J.A.C. 10:52-11.8(b)* and (c) multiplied by the Medicaid/NJ FamilyCare payment rate.

2. In the event that there is a partial payment from a third party, the charity care write-off amount is determined as follows: Charity Care Write-Off Amount equals Medicaid/NJ FamilyCare payment rate minus third party payment multiplied by Charity Care Eligibility Percentage. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to all Federal disproportionate share rules, including the Omnibus Budget Reconciliation Act of 1993, Section 13621.

3. If the third-party payment is greater than the Medicaid/NJ FamilyCare payment rate, the charity care write-off amount shall be listed as zero.

(b) Applicants eligible for charity care at 100 percent shall not be billed. Any difference between hospital charges and the Medicaid/NJ FamilyCare rate shall be recorded as a contractual allowance.

(c) Applicants eligible for charity care at less than 100 percent shall be billed as follows:

1. Applicant Responsibility equals 100 percent minus Charity Care Eligibility Percentage multiplied by Hospital Charges minus any third party payment.

2. Contractual allowance equals Hospital Charges minus any third party payment minus Charity Care Write Off plus Applicant Responsibility.

(d) The Department of Health will calculate the cost of charity care services at the rate that would have been paid by the New Jersey Medicaid/NJ FamilyCare program.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a)1, changed N.J.A.C. reference; and in (d), substituted a reference to the Department of Health and Senior Services for a reference to the Essential Health Services Commission.

Amended by R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

In (a), rewrote the introductory paragraph, and changed N.J.A.C. reference in 1.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid, NJ FamilyCare, and the Department of Health throughout; in (a)1 and (a)2, substituted "Write-Off" for "Write Off"; and in (a)3, substituted "third-party" for "third party".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-11.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.4 Differing documentation requirements if patient admitted through emergency room

N.J.A.C. 10:52-11.5 through 11.10 govern documentation requirements for all charity care applications except those for patients admitted through the hospital's emergency room. Documentation requirements for applications of patients admitted through the emergency room are governed by N.J.A.C. 10:52-11.16.

History

HISTORY:

New Rule, R.2000 d.299, effective July 17, 2000.

See 32 New Jersey Register 1123(a), 32 New Jersey Register 2615(a).

Former N.J.A.C. 10:52-11.4, Charity care screening and documentation requirements, recodified to N.J.A.C. 10:52-11.5.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.5 Charity care screening and documentation requirements

(a) The hospital shall provide all patients with an individual written notice of the availability of charity care and Medicaid/NJ FamilyCare, in a form provided by the Department of Health, at the time of service, but no later than the issuance of the first billing statement to the patient.

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this subchapter. The applicant's financial file for audit shall contain the completed charity care application in a format approved by the Department of Health, as well as the supporting documentation which led to the determination of eligibility. For purposes of the audit, the hospital shall include in or with the file all other information necessary to demonstrate compliance with any of the audit steps.

(c) The hospital shall ask the applicant if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers compensation policy. If the applicant claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified, or the reason why the coverage could not be verified. Verification of insurance shall include the hospital contacting the identified third party insurer. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(d) If the applicant is uninsured, or the applicant's health insurance is unlikely to pay the bill in full (based on hospital staff's previous experience with the insurer), and the applicant has not paid at the time of service any amounts likely to be remaining, the hospital shall make an initial determination for eligibility for any medical assistance programs available. The hospital shall refer the applicant to the appropriate medical assistance program and shall advise the medical assistance office of the applicant's possible eligibility. The applicant's financial file for audit shall indicate either that the applicant declined to be screened for medical assistance; that the applicant was screened but was determined ineligible; or that the applicant was screened and referred to the medical assistance program for possible eligibility. If the hospital does not screen the applicant for medical assistance, the record shall indicate the reason(s) why the applicant was not screened and the efforts the hospital made to obtain the screening. If an applicant affirmatively declines to be screened or is referred to a medical assistance program and does not return with an appropriate determination, the hospital will use the following procedures:

1. If the applicant affirmatively declines to be screened, or does not complete the medical assistance application process within three months after the date of service, or files an application after the application deadline, but is otherwise documented as eligible for charity care, the hospital:

i. May bill the applicant, consistent with the manner applied to other patients;

ii. Shall report the Medicaid/NJ FamilyCare value amount as charity care; and

iii. Shall report any amounts collected from the applicant or any third party as a charity care recovery.

2. If the hospital has not received a response to the medical assistance application from the county board of social services or other medical assistance office within seven months of receipt of a complete application, the hospital shall approve the applicant's charity care application if the applicant meets all other charity care criteria. Should medical assistance be approved following the hospital's charity care approval, the hospital shall report the amounts collected from the medical assistance program as a charity care recovery and issue a redetermination that states that because the applicant is eligible for medical assistance, he or she is no longer eligible for charity care.

3. If the hospital does not inform the applicant of medical assistance by the individual written notice required in (a) above or does not refer an applicant who could reasonably be considered eligible for a medical assistance program within three months of the date of service, the hospital shall record the applicant's bill as a courtesy adjustment and shall not bill or otherwise attempt to collect from the applicant or the Charity Care Program.

(e) Hospitals shall make arrangements for reimbursement for services from private sources, and Federal, state and local government third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing the services to charity care except in the situations described in (h) and (i) below. The hospital shall, as part of this obligation, pursue reimbursement for the uncollected copayments and deductibles of indigent participants in Title XVIII of the Social Security Act (Medicare). Hospitals shall report any amounts collected from any third party as a charity care recovery. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(f) An applicant who is responsible for complying with his or her insurer's pre-certification requirements (the specific steps with which the insured must comply in order to have the services reimbursed) shall not be determined to be eligible for charity care, if the bill was unpaid because he or she failed to comply with these requirements. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(g) An applicant who is determined to be eligible for, and is accepted into, the HealthStart Program shall not be deemed eligible for charity care for services which are covered under this program. Beginning July 1, 1995, charity care availability shall be subject to Federal disproportionate share rules.

(h) Applicants who are eligible for reimbursement under the Violent Crimes Compensation Program shall be screened for eligibility for charity care before referral to the Violent Crimes Compensation Program (see *N.J.A.C. 13:75*). If the applicant is not eligible for 100 percent coverage under charity care, the charges which are not eligible for coverage under charity care shall be referred to the Violent Crimes Compensation Program. The hospital shall request the applicant to submit a copy of his or her charity care determination form to the Violent Crimes Compensation Board.

(i) Applicants who are eligible for reimbursement under the Catastrophic Illness in Children Relief Fund shall be screened for eligibility for charity care before referral to this Fund. If the applicant is not eligible for 100 percent coverage under charity care, the applicant shall be referred to the Catastrophic Illness in Children Relief Fund (see *N.J.A.C. 10:155*) for the uncovered portion of the claims.

(j) Hospitals with a Federal Hill-Burton obligation at the time of the application may include applicants written-off to the Hill-Burton Program as eligible for charity care if the applicant meets all of the eligibility standards and documentation requirements set forth in this section through *N.J.A.C. 10:52-11.10*.

(k) The Charity Care Program shall be the payer of last resort, except for the payers identified in (h) and (i) above.

(l) A charity care applicant shall be eligible for charity care for services rendered per *N.J.A.C. 8:31B-4.38* on or after January 1, 1995 if he or she meets the criteria in this subchapter.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a) and (b), substituted references to the Department of Health and Senior Services for references to the Essential Health Services Commission; in (d)2, substituted a reference to county boards of social services for a reference to county welfare offices; and in (i), (j) and (*l*), changed N.J.A.C. references.

Recodified from 10:52-11.4 and amended by R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

In (b) and (*l*), changed N.J.A.C. references. Former *N.J.A.C. 10:52-11.5*, Identification, recodified to *N.J.A.C. 10:52-11.6*.

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

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

In (a), substituted "FamilyCare" for "KidCare".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), substituted "Medicaid/NJ" for "Medicaid or NJ"; in (a) and (b), deleted "and Senior Services" following "Health"; and in (d)1ii, substituted "Medicaid/NJ FamilyCare" for "Medicaid".

Annotations

Notes

Chapter Notes

Case Notes

In a case in which a hospital sought to count its New Jersey Charity Care Program (NJCCP) patients in its Medicare disproportionate share hospital calculation, the Secretary of Health and Human Services' interpretation, through the Centers for Medicare and Medicaid Services (CMS), that the phrase, patients who were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, found in *42 U.S.C.S. § 1395ww(d)(5)(F)(vi)(II)*, included only patients who were eligible for traditional Medicaid was reasonable. That NJCCP did not provide medical assistance under *42 U.S.C.S. § 1396d(a)* was fatal to the hospital's claim because the CMS reasonably determined that the Medicaid proxy fraction at issue incorporated the definition of medical assistance from the Medicaid statute. *Cooper Univ. Hosp. v. Sebelius, 686 F. Supp. 2d 483, 2009 U.S. Dist. LEXIS 89912 (2009)*.

N.J.A.C. 10:52-11.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.6 Identification

(a) Applicants for charity care shall provide the hospital with the following proper identification: paragraph (a)3 below represents an alternative measure for documenting identification as described in *N.J.A.C. 10:52-11.11*.

1. The applicant shall provide the hospital with one of the following identification documents: driver's license, social security card, alien registry card, birth certificate, baptismal certificate, paycheck stub, passport, visa, death certificate, employee identification, or attestation that the person is homeless and does not possess any of the above mentioned identification documents. If the documents listed above are not available to the applicant, the hospital staff shall document why the applicant was unable to comply, and shall ask for one of the identification documents listed in (a)2 below. If the applicant is unable to comply for medical reasons, such as, if the applicant is deceased, or noncommunicative until discharge for medical reasons, and a person to identify the patient cannot be found, the requirement for identification shall be waived.

2. The applicant shall provide the hospital with one of the following documents containing his or her name and address: a driver's license, a voter registration card, a union membership card, an insurance or welfare plan identification card, a student identification card, a utility bill, a Federal income tax form, a state income tax form, or an unemployment benefits statement. If the documents listed above are not available to the applicant, the hospital staff shall document why the applicant was unable to comply and shall ask for proof of identification as described in (a)3 below.

3. The applicant shall provide proof of identification in one of the following ways: a piece of mail addressed and delivered to the applicant; a signed attestation (which includes the party's name, address and telephone number) from a third party attesting to the applicant's identity; or a signed statement attesting to his or her own identity.

(b) The hospital shall obtain a photocopy of the applicant's identification or attestation and shall produce the copy on audit.

(c) The hospital shall attempt to collect the following information regarding the applicant and, if applicable, the responsible party: name; mailing address; residence telephone number; date of birth; social security number; place and type of employment; and employment address and telephone number, as applicable.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (a), changed N.J.A.C. reference in the introductory paragraph, inserted a reference to baptismal certificates and paycheck stubs in 1, and inserted a reference to drivers licenses and deleted a reference to baptismal certificates and paycheck stubs in 2.

Recodified from 10:52-11.5 and amended by R.2000 d.299, effective July 17, 2000.

See: *32 New Jersey Register 1123(a)*, *32 New Jersey Register 2615(a)*.

In (a), changed N.J.A.C. reference. Former *N.J.A.C. 10:52-11.6*, New Jersey residency, recodified to *N.J.A.C. 10:52-11.7*.

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

See: *37 New Jersey Register 436(a)*, 37 New Jersey Register 2056(a).

In (a), inserted ", and shall ask for one of the identification documents listed in (a)2 below. If the applicant is unable to comply" preceding "for medical reasons" in 1.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.7 New Jersey residency

(a) Applicants for charity care shall provide the hospital with proof of New Jersey residency. An applicant shall provide proof that he or she has been residing in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. Paragraph (a)3 below represents an alternative measure for documenting proof of residency.

1. The applicant shall provide the hospital with any of the identification documents listed in *N.J.A.C. 10:52-11.6(a)*2 that contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. The hospital may accept an attestation from the applicant that he or she is homeless. If the applicant is unable to provide one of the documents listed at *N.J.A.C. 10:52-11.6(a)*2, the hospital staff shall document why the applicant was unable to comply, and shall ask for proof of residency as described in (a)2 below.

2. If the applicant cannot provide any of the documentation listed in *N.J.A.C. 10:52-11.6(a)*2, the applicant shall supply a copy of any undated identification listed in *N.J.A.C. 10:52-11.6(a)*1 and this paragraph, or any mail received showing the applicant's name and current residence address. If the applicant is unable to provide these documents, the hospital staff shall document why the applicant was unable to comply and ask for proof of residency as described in (a)3 below.

3. The applicant shall provide a signed attestation stating that he or she has been residing in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State.

(b) Non-New Jersey residents requiring immediate medical attention for an emergency medical condition may apply for charity care. Emergency medical condition shall be restrictively defined as a serious medical situation requiring immediate treatment, in which delay would cause serious risk to life or health. Services available to non-New Jersey residents shall include only those not reasonably available at an alternative non-New Jersey site at the time services are requested.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (a), changed N.J.A.C. references throughout, and rewrote 2.

Recodified from 10:52-11.6 and amended by R.2000 d.299, effective July 17, 2000.

See: *32 New Jersey Register 1123(a)*, *32 New Jersey Register 2615(a)*.

In (a), changed N.J.A.C. references throughout. Former *N.J.A.C. 10:52-11.7*, Income eligibility criteria and documentation, recodified to *N.J.A.C. 10:52-11.8*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.8 Income eligibility criteria and documentation

(a) The hospital shall determine the applicant's family size in accordance with this section. Family size for an adult applicant includes the applicant, spouse, any minor children whom he or she supports, and adults for whom the applicant is legally responsible. The family size for a minor applicant includes both parents, the spouse of a parent, minor siblings and any adults in the family for whom the applicant's parent(s) are legally responsible. If an applicant documents that he or she has been abandoned by a spouse or parent, that spouse or parent shall not be included as a family member. A pregnant female counts as two family members.

(b) The provisions of *42 U.S.C. § 9902(2)*, the poverty guidelines revised annually by the United States Department of Health and Human Services (HHS), are hereby incorporated by reference. (For further information on the poverty guidelines, contact the Office of the Assistant Secretary for Planning and Evaluation, Room 415F, Department of Health and Human Services, 200 Independence Avenue, SW Washington, D.C. 20201, Telephone (202) 690-7858; Website: *https://aspe.hhs.gov/*.) A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

1. A person whose individual or, if applicable, family income, as determined by (e) below, is less than or equal to 200 percent of the HHS Poverty Guidelines shall be eligible for charity care for necessary health services without cost.

2. A person whose individual or, if applicable, family, income as determined by (e) below, is greater than 200 percent of the HHS Poverty Guidelines but not more than 300 percent of these guidelines is eligible for charity care at a reduced rate as described in (c) below.

(c) A person who is eligible for reduced charge health services shall be charged a percentage of the normal charge for health services as described in the table below. The reduced percentage can be applied to the total bill or, until July 1, 1995, to any remainder after third party payment. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

Income as a percentage of HHS Poverty Guidelines	Percentage of Charges Paid by Applicant
>200 to 225	20
>225 to 250	40
>250 to 275	60
>275 to 300	80

(d) If qualified medical expenses, as defined for the purposes of Federal income tax deductibility, for applicants eligible for reduced charge charity care exceeds 30 percent of the applicant's or family's, if applicable, annual gross income as calculated by (e) below, such excess will be eligible for 100 percent coverage under charity care. The 30 percent threshold must be met once per family in a 12 month period.

(e) An applicant's income, for the purpose of determining eligibility for charity care or reduced charge charity care, shall be determined as follows:

1. The applicant may provide proof of the actual gross income for the 12 months immediately preceding the services;

2. The applicant may provide proof of actual gross income for the three months immediately preceding services. The hospital shall multiply this amount by four to determine the gross annual income; or

3. The applicant may provide proof of actual gross income for the month immediately preceding service. The hospital shall multiply this amount by 12 to determine the gross annual income.

4. If the applicant provides documentation for more than one salary period specified in paragraphs (e)1 through 3 above, the hospital shall use the period of time during which the salary was the lowest.

5. If the applicant is a welfare recipient and has not documented income as described in (e)1 through 3 above, the hospital shall document income status by obtaining a photocopy of the applicant's welfare identification, and document that the staff of the hospital obtained verification in writing or by phone of the applicant's current benefit amount from the appropriate local welfare office.

6. An applicant shall supply a signed attestation showing his or her unreported income in order for that income to be considered in the eligibility determination, as described in (b) above.

History

HISTORY:

Recodified from 10:52-11.7 by R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

Former *N.J.A.C. 10:52-11.8*, Proof of income, recodified to *N.J.A.C. 10:52-11.9*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (b), inserted "§ ", "Room 415F", and "200 Independence Avenue, SW", and substituted "7858; Website: *http://aspe.hhs.gov/*" for "6141".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-11.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.9 Proof of income

(a) Applicants for charity care shall provide the hospital with proof of income as listed below. Paragraph (a)3 below shall be considered alternative documentation, as described in *N.J.A.C. 10:52-11.11*.

1. An applicant shall provide the hospital with proof of income, which includes the following items: Federal or State income tax return; pay check stubs; W-2 forms; a letter from an employer on company letterhead stating the applicant's income; or a statement of the gross benefit amount from any governmental agency providing benefit to the applicant. If an applicant has been employed for at least one month, he or she may document his or her income by providing one paycheck stub immediately prior to the date of service if the paycheck stub indicates a year-to-date income, and if the applicant documents the length of time he or she has been employed by the employer.

i. If an applicant is a recipient of Social Security benefits, he or she may document this income by either providing the annual benefits statement from the Social Security Administration, or copies of bank statements from three months prior which indicate direct deposit of the social security check, or a copy of one social security check.

ii. An applicant with no income or benefits of any type may present the hospital with a signed attestation to this effect. If the applicant is homeless, the hospital may accept a signed attestation which states that the applicant is homeless and receives no support, income or benefits.

iii. If the applicant is unable to provide one of the documents listed above, the hospital staff shall document reasons for the applicant's inability to comply and request the documentation listed in (a)2 below.

2. An applicant may document his or her income by providing one paycheck stub immediately prior to the date of service. If the applicant is unable to provide this documentation, the hospital staff must document reasons for the applicant's inability to comply and request the documentation listed in (a)3 below.

3. An applicant may document his or her income by providing an attestation which states the income received in one of the time periods described in *N.J.A.C. 10:52-11.8(e)*1 through 3.

(b) Family income that must be considered for the eligibility determination includes the income of all members for whom the applicant is legally responsible including, but not limited to, a spouse and any minor children for an adult. For a minor applicant, the income of the family, as determined by *N.J.A.C. 10:52-11.8(a)*, will be considered. In situations where a minor applicant's parents are divorced, and the custodial parent(s) are remarried, the nonparental spouse's income shall be considered. In situations where both divorced parents have responsibility for the minor applicant's medical care, each parent shall complete a charity care application. For a minor applicant, the income of the family shall be considered, except for earned income of the minor child and siblings. In cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available by the following steps in (c) below.

(c) If a minor applicant's parents are divorced, and one of the parents is uncooperative, as defined in (c)1 through 3 below, with the application process, the requirement for that parent's income may be waived by the hospital, after the case is reviewed by the Department of Health based on the following:

1. A parent or spouse may be deemed uncooperative if the applicant documents at least one unsuccessful attempt to obtain the necessary information from the parent or spouse; and

2. The parent or spouse does not respond to a letter from the hospital indicating the possibility of collection or legal action if he or she does not provide the necessary information for the application; and

3. The parent or spouse does not respond to the hospital in-house collection process.

(d) If an applicant is separated, but not legally divorced, from his or her spouse, the applicant may document that he or she has no financial ties with the estranged spouse in accordance with (d)1 through 4 below, and the hospital may waive the requirement for the estranged spouse's income, after the case is reviewed by the Department of Health, if documentation has been provided in accordance with the following:

1. A separated spouse may be deemed to have no financial ties to the applicant if the applicant provides proof to the hospital that he or she is not living with the estranged spouse, and does not own any property or share a lease to a rental property with the estranged spouse; and

2. The applicant provides a copy of his or her most recent tax return indicating that the applicant filed taxes separately. If estrangement occurred after filing jointly, the hospital may hold the application until the applicant files the next tax return separately. If an applicant does not file tax returns, he or she must sign an attestation to this effect explaining his or her reasons; and

3. The applicant provides copies of all his or her financial accounts showing the applicant with sole ownership of his or her assets; and

4. The applicant provides an affidavit stating that he or she is separated from and has no financial ties to the estranged spouse.

(e) The hospital may request that the applicant document his or her living expenses.

(f) A minor applicant who documents that both parents have abandoned him or her shall provide documentation of the income and assets of his or her guardian(s).

(g) The hospital may accept a charity care determination from another New Jersey hospital as proof of income, provided that the effective date of the charity care determination is not more than one year earlier than the date of service at the second hospital and that the second hospital verifies the determination with the hospital that issued the determination. The determination by the second hospital is valid for one year from the effective date of the first hospital's determination.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a) and (b), changed N.J.A.C. references throughout.

Recodified from 10:52-11.8 and amended by R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

In (a) and (b), changed N.J.A.C. references throughout. Former *N.J.A.C. 10:52-11.9*, Assets eligibility criteria, recodified to *N.J.A.C. 10:52-11.10*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (c) and of (d), deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.10 Assets eligibility criteria

(a) An applicant shall provide proof that:

1. His or her individual assets as of the date of service do not exceed $ 7,500; and

2. His or her family's assets, if applicable, do not exceed $ 15,000 as of the date of service.

(b) Family members whose assets must be considered are all legally responsible individuals as defined in *N.J.A.C. 10:52-11.8(a)*.

(c) Assets, as used in this section, are items which are, or which can be readily converted into, cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, Individual Retirement Accounts (IRAs), trust funds, and equity in real estate other than the applicant's or family's, if applicable, primary residence. A primary residence, for purposes of charity care, is defined as a structure within which the applicant currently lives. If an applicant jointly owns assets with another person(s), for whom the applicant is not legally responsible, the value of these assets shall be prorated equally among all the owners.

(d) The applicant shall document the value of all applicable assets as described in (d)1 through 3 below. Paragraph (d)3 below represents alternative documentation as described in *N.J.A.C. 10:52-11.8*.

1. The applicant shall present the hospital with a statement from a bank or other applicable financial institution showing the value of the asset(s) as of the date of service. If an applicant has no assets, he or she may sign an attestation to that effect, and this fulfills the requirement for proof of assets. If the applicant is unable to obtain such documentation, the hospital staff shall document, in writing, the reason why the proof could not be provided, and request proof of assets as described in (d)2 below.

2. The applicant shall provide the hospital with a statement from the bank or other applicable financial institution showing the average daily balance of the asset(s) within one month of the date of service. If the applicant is unable to obtain such documentation, the hospital staff shall document, in writing, the reason why the proof could not be provided, and request proof of assets as described in (d)3 below.

3. The applicant shall present the hospital with a signed statement attesting to the type and value of the assets.

(e) The assets of an applicant for charity care shall be counted only after the applicant has had an opportunity to apply any amount of assets in excess of the limits in (a) above toward qualified medical expenses. Qualified medical expenses are those amounts deductible for the purpose of calculation of Federal income tax liability.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 New Jersey Register 3151(a)*, *32 New Jersey Register 276(a)*.

In (b) and (d), changed N.J.A.C. references.

Recodified from 10:52-11.9 and amended by R.2000 d.299, effective July 17, 2000.

See: *32 New Jersey Register 1123(a)*, *32 New Jersey Register 2615(a)*.

In (a) and (d), changed N.J.A.C. references. Former *N.J.A.C. 10:52-11.10*, Limit on accounts with alternative documentation, recodified to *N.J.A.C. 10:52-11.11*.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-11.11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.11 Limit on accounts with alternative documentation

The total of all sample dollars in which identification, New Jersey residency, income, and assets documented by the alternative procedures described in *N.J.A.C. 10:52-11.6(a)*3, 11.7(a)3, 11.9(a)3, or 11.10(d) 3 shall be limited to no more than 10 percent of the total dollars sampled on audit. Sample dollars that exceed 10 percent on the expanded sample shall be adjusted in accordance with *N.J.A.C. 10:52-11.15(b)*.

History

HISTORY:

Recodified from 10:52-11.10 and amended by R.2000 d.299, effective July 17, 2000.

See: *32 New Jersey Register 1123(a)*, *32 New Jersey Register 2615(a)*.

Changed N.J.A.C. references throughout. Former *N.J.A.C. 10:52-11.11*, Additional information to be supplied to facility by applicant, recodified to *N.J.A.C. 10:52-11.12*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.12

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.12 Additional information to be supplied to facility by applicant

(a) A hospital shall, as a condition of finding any applicant eligible for charity care or reduced charge charity care, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and assets and that is within the applicant's ability to supply.

(b) An applicant who willfully presents false information will be liable for all hospital charges and subject to civil penalties pursuant to *N.J.S.A. 26:2H-18.63*.

History

HISTORY:

Recodified from 10:52-11.11 by R.2000 d.299, effective July 17, 2000.

See: *32 New Jersey Register 1123(a)*, *32 New Jersey Register 2615(a)*.

Former *N.J.A.C. 10:52-11.12*, Application and determination, recodified to *N.J.A.C. 10:52-11.13*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.13

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.13 Application and determination

(a) Consistent with the requirements of *N.J.A.C. 10:52-11.6*, *11.7*, *11.8*, *11.9*, *11.10*, *11.11*, and *11.12*, the Department of Health shall specify the elements to be included in charity care application and eligibility determination forms used by all disproportionate share hospitals for the Charity Care Program; hospitals shall not omit or add to these elements. The application form shall advise patients of the penalties for providing false information on a charity care application. The list of required elements may be obtained from the Department of Health, Division of Health Services Oversight, Hospital Financial Reporting and Support.

(b) An applicant or responsible party may submit a completed application for a hospital to make a determination for charity care or reduced charge charity care at any time up to one year from the date of outpatient service or inpatient discharge. The hospital shall make the charity care determination and notify the applicant in writing, as soon as possible, but no later than 10 working days from the day the applicant submits a completed initial application. If the application does not include sufficient documentation to make the determination, the hospital shall notify the applicant, in writing, as soon as possible, but no later than 10 working days from the day the applicant submits an incomplete application. The applicant shall be permitted to supply additional documentation at any time up to one year after the date of discharge (inpatient) or service (outpatient). At the hospital's discretion, the hospital may accept a completed application within two years of the date of service (outpatient) or date of discharge (inpatient).

(c) A determination that an applicant is eligible shall indicate:

1. The date on which the eligibility determination was made;

2. The date on which hospital services were requested;

3. The date on which the services were or will be provided to the applicant;

4. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;

5. The applicant's family size, income and eligibility computation;

6. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old; and

7. The name and telephone number of a person a hospital can contact to verify eligibility.

(d) The hospital shall provide each applicant who requests charity care and is denied it, in whole or part, with a written and dated statement of the reasons for the denial, including information required in (c) above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. Where a denial is based on a presumption that the applicant is eligible for, but not enrolled in Medicaid/NJ FamilyCare, the information upon which the denial is based must be documented.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (a), substituted a reference to the Department of Health and Senior Services for a reference to the Essential Health Services Commission; in (c)7, deleted N.J.A.C. reference; and in (d), inserted a reference to NJ KidCare.

Recodified from 10:52-11.12 by R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

Former *N.J.A.C. 10:52-11.13*, Collection procedures and prohibited action, recodified to *N.J.A.C. 10:52-11.14*.

Amended by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

Rewrote (a) and (b); in (d), substituted "FamilyCare" for "KidCare".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), deleted "and Senior Services" following "Health" twice, and inserted a comma following "11.11"; and in (d), substituted "Medicaid/NJ" for "Medicaid or NJ".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-11.14

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.14 Collection procedures and prohibited action

Persons determined to be eligible for charity care shall not receive a bill for services or be subject to collection procedures. Persons determined to be eligible for reduced charge charity care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge charity care.

History

HISTORY:

Recodified from 10:52-11.13 by R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

Former *N.J.A.C. 10:52-11.14*, Adjustment methodology, recodified to *N.J.A.C. 10:52-11.15*.

Annotations

Notes

Chapter Notes

Case Notes

Where an indigent mental health patient was involuntarily committed to a hospital's short-term care facility after being screened by a psychiatric emergency screening service (PESS), the trial court erred in ruling that the hospital was entitled to recover from the patient based on a theory of quasi-contract under the procedures governing a regular admission; when a mental health patient was admitted to a hospital on an emergent basis through the referral of a PESS, the provisions of the charity care regulations dealing with emergency room admissions applied, and as the hospital did not contact the patient by phone, schedule an in-person interview with him, or send a social worker to his home to obtain the information needed to process his charity care application, it was barred from recovering from him. *Newton Med. Ctr. v. D.B., 2018 N.J. Super. LEXIS 8 (2018)*.

N.J.A.C. 10:52-11.15

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.15 Adjustment methodology

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

"Alternative documentation adjustment" means an adjustment to a hospital's charity care write-off amount as a result of the periodic audits of a sample of claims submitted during a calendar year. This audit determines whether the total value of sampled claims that are documented by the alternative procedures described in *N.J.A.C. 10:52-11.6(a)*3, 11.7(a)3, 11.9(a)3 or 11.10(d)3, exceeds permitted limits.

"Charity care write-off amount" means the rendered charity care services, priced at the rate used by the Medicaid program before adjustment, if any, for direct graduate medical education and indirect medical education factors.

"Compliance adjustment" means an adjustment to a hospital's charity care write-off amount as a result of the periodic audits of a sample of claims submitted during a calendar year. This audit determines whether there is appropriate documentation showing that all charity care eligibility requirements at *N.J.A.C. 10:52-11.5* through *11.11* and *11.16* have been met.

"Listing adjustment" means an adjustment to a hospital's charity care write-off amount as a result of the audit of a sample of these claims submitted during a calendar year. The purpose of this audit is to ensure that the claims contain only those charges that are eligible for reimbursement.

(b) The charity care write-off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid/NJ FamilyCare program. To the extent that a hospital's total charity care write-off amount is overstated, the amount will be reduced by the amount of the overstatement.

(c) In addition to adjustments required to ensure that the charity care write-off amount is equal to the Medicaid/NJ FamilyCare reimbursement rates, the write-off amount may also be revised on the basis of listing, alternative documentation and/or compliance adjustments, in that order.

(d) Examples of listing adjustments include changes made if:

1. Medicare or other third-party payer payments were not reflected in the claim;

2. Ineligible expenses, such as standard convenience or personal comfort items as listed in Uniform Billing requirements, are included; or

3. The percentage of the claim to be written off to charity care, based on the hospital's determination of the applicant's eligibility, was erroneous.

(e) In accordance with the provisions of *N.J.A.C. 10:52-11.11*, use of alternative documentation in any one of the steps to determine an applicant's eligibility for charity care shall cause that applicant's file to be designated as an alternative documentation file. A ratio shall be developed using sample dollars with alternative documentation as a percentage of total sample dollars. If this ratio is less than or equal to.10, there shall be no adjustment. If this ratio is greater than.10, the ratio shall be reduced by.10 and then multiplied by the hospital's charity care write-off amount at the Medicaid/NJ FamilyCare rate for the

calendar year being audited. This amount shall be subtracted from the hospital's charity care write-off amount for the calendar year being audited at the Medicaid rate after listing adjustment.

(f) In accordance with the provisions of *N.J.A.C. 10:52-11.5* through *11.11*, noncompliance with any one of the steps to determine an applicant's eligibility for charity care shall cause that applicant's file to be designated as a failed compliance file. A ratio shall be developed using sample dollars from failed compliance files as a percentage of total sample dollars. If this ratio is less than.10, there shall be no adjustment. If this ratio is equal to or greater than.10, the ratio shall be multiplied by the hospital's charity care write-off amount for the calendar year being audited at the Medicaid/NJ FamilyCare rate. This amount shall be subtracted from the hospital's charity care write-off amount at the Medicaid rate after alternative documentation adjustment.

(g) The hospital's charity care write-off amount total adjusted for (d), (e) and (f) above will constitute the hospital's audited charity care write-off amount for claims submitted during the calendar year being audited, except for further adjustments that may occur in accordance with *N.J.A.C. 10:52-13.4*.

(h) The Department of Health's auditor will provide the hospital with a copy of its audit findings and recommended adjustments. Eligible hospitals shall sign the auditor's audit findings, indicating their agreement or disagreement with the audited charity care write-off amount. If the hospital disagrees with the audit findings, the hospital shall submit a request for a departmental review within 15 days of receiving the auditor's report and shall, within the request, detail the reasons for disagreement with the auditor's findings. The Department will review the auditor's findings, as well as the hospital's objections, and will advise the hospital within 30 days of receipt of the request for review of the total dollar value of the hospital's charity care write-off for the period audited, priced at the Medicaid/NJ FamilyCare rate.

(i) A hospital which disagrees with the audit findings may request an administrative hearing, which shall be conducted in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1* et seq., and the Uniform Administrative Procedure Rules, *N.J.A.C. 1:1*.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (c), changed N.J.A.C. reference.

Recodified from 10:52-11.14 and amended by R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

In (c), changed N.J.A.C. reference.

Amended by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

Rewrote the section.

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

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

In (a), amended the N.J.A.C. references in "Compliance adjustment".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid, NJ FamilyCare, and the Department of Health throughout.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-11.16

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.16 Charity care applications of patients admitted through emergency room

(a) If a charity care applicant is admitted through the hospital's emergency room, the requirements set forth in this section shall apply.

1. The hospital shall notify the patient, orally and by providing a copy of the individual written notice referenced in *N.J.A.C. 10:52-11.5(a)*, of the availability of charity care. This notice shall be given prior to the patient's discharge from the hospital.

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this section. The applicant's financial file for audit purposes shall contain the supporting documentation described in this section.

(c) If the applicant's medical condition permits, the hospital shall ask the applicant, prior to discharge, if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers' compensation policy. If the applicant claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified, or the reason why the coverage could not be verified. Verification of insurance shall include the hospital contacting the identified third party insurer. Charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(d) If the applicant's medical condition permits, the hospital shall also, prior to the applicant's discharge, request the following information, which shall be recorded by the hospital on a form approved by the Department of Health:

1. The applicant's name;

2. The address of the applicant's residence;

3. Whether the applicant intends to remain a resident of New Jersey (assuming current residence in New Jersey);

4. The applicant's home telephone number, if any;

5. Whether the applicant is employed and, if so, the employer's name and address;

6. Applicant's best estimate of annual income, including sources of income and income from each source; and

7. Whether the applicant has an account with a bank and, if so, the name and location of the bank.

(e) If the hospital is able to obtain the information listed in (d) above, the hospital shall, prior to the applicant's discharge, ask the applicant to read the form on which the information has been recorded, and verify the information's accuracy by signing the form. The form shall also include a statement authorizing the hospital to contact any person or entity listed on the form in order to obtain and/or verify information relating to the charity care application.

(f) The hospital shall verify that the applicant is not enrolled in a medical assistance program.

(g) If the applicant is determined to be uninsured and not enrolled in a medical assistance program, and the hospital has been able to obtain the information and applicant's signature described in (d) and (e) above, then the hospital shall process the charity care application based on the information obtained. (If the information and applicant's signature described in (d) and (e) above cannot be obtained by the hospital, in whole or in part, then the provisions of (h) below shall apply.) The applicant's charity care eligibility shall be determined based on the following requirements:

1. The applicant's self-identification shall be acceptable to establish identity;

2. The applicant shall be a resident of New Jersey at the time of service, and shall have the intent to remain in the State as demonstrated by the applicant's statement of intent. The hospital shall verify, by telephone or visit, that the applicant can be contacted at the address provided; if the address is in the State, this shall establish New Jersey residency for this purpose. The method of verification shall be documented in the financial file for audit purposes;

3. There shall be an assumption that the applicant's family size, for purposes of the charity care application, is one, consisting of the applicant. The charity care income eligibility guidelines set forth at *N.J.A.C. 10:52-11.8(b)* and (c) shall be applied to determine eligibility. If the applicant identified an employer, the hospital shall contact that employer to determine the applicant's income. The hospital shall record that information, if provided, and include it in the financial file for audit purposes. If the employer declines to provide that information, that fact shall likewise be documented. The hospital shall annualize any income amount provided by the employer, if necessary, to assess the applicant's eligibility. If the applicant did not identify an employer, or the employer declines to provide income information regarding the applicant, then the applicant's best estimate of annual income (see (d) above) shall be used to determine the applicant's annual income for this purpose; and

4. There shall be an assumption for the purposes of this section that bank account deposits constitute the only assets relevant to the application. If the applicant identified a bank at which he or she holds deposits, then the hospital shall contact the bank to verify the amount held. If the bank provides the requested information, then the amount shall be documented in the financial file for audit purposes. If the bank declines to provide the information, that fact shall likewise be documented. If no bank was identified by the applicant, or the bank declines to provide information regarding the account, there shall be an assumption that the applicant has no assets. Eligibility shall be assessed under the asset limitation set forth at *N.J.A.C. 10:52-11.11(a)*1.

(h) If the applicant is determined to be uninsured and not enrolled in a medical assistance program, and if the hospital was unable to obtain the information and applicant signature described in (d) and (e) above, then the hospital shall make the following efforts to determine whether the applicant is eligible for charity care. The hospital shall:

1. Make at least two attempts to contact the patient by phone, if a phone number is available, to try to schedule an in-person interview to obtain information relevant to the application. If such an interview can be arranged, the hospital shall obtain the relevant information and process the application based on that information. If such an interview cannot be arranged, this shall be documented in the financial file for audit purposes;

2. Visit the address given by the applicant, or otherwise obtained, and attempt to verify that the applicant lives there. If the applicant is homeless and has not provided the address of a shelter or other temporary residence, this requirement shall not apply. This shall be achieved by direct contact with the applicant, if possible, or by asking persons at the address, neighbors, or by observing the surroundings (for example, name on mailbox). The results of this attempt shall be documented in the financial file for audit purposes. If the hospital is able to achieve direct contact with the applicant, the hospital shall try to conduct or schedule an in-person interview to obtain information relevant to the application. If such an interview can be arranged, the hospital shall obtain the relevant information and process the

application based on that information. If such an interview cannot be arranged, this shall be documented in the financial file for audit purposes; and

3. Attempt to determine the applicant's income and assets, that shall include observing the nature of the applicant's housing, to determine that there are no indications that the applicant would not likely be eligible for charity care, and obtaining information from persons at the applicant's address or from neighbors regarding the applicant's employment or other means of support. The results of these attempts shall be documented in the financial file for audit purposes.

(i) If the applicant is determined to be eligible for charity care under (g) above or, in the alternative, if the hospital has completed and documented the efforts set forth in (h) above, then the hospital may write off to charity care the claim(s) arising from the admission. Notwithstanding any other provision of this subchapter, if an applicant is determined to be eligible for charity care under (g) above, or in the alternative, if the hospital has completed and documented the efforts set forth in (h) above, and the patient is subsequently transferred to, and admitted at, another hospital, then the hospital admitting the transferred patient may rely upon the charity care determination of the transferring hospital, and write off to charity care the claim(s) arising from the transfer admission. See *N.J.A.C. 10:52-11.3* regarding the charity care write off amount. The applicant shall not be deemed to be eligible for charity care for future services based on this determination but would, instead, be required to meet the requirements set forth at *N.J.A.C. 10:52-11.5* through *11.10* and *11.12* at the time that future services were rendered unless the applicant was admitted through the emergency room in the future, in which case this section would apply.

(j) Claims that are written off to charity care under (i) above shall not be included when determining the "alternative documentation" adjustment. See *N.J.A.C. 10:52-11.11* and *11.15*.

History

HISTORY:

New Rule, R.2000 d.299, effective July 17, 2000.

See: *32 N.J.R. 1123(a)*, *32 N.J.R. 2615(a)*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (d), deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

Case Notes

Where an indigent mental health patient was involuntarily committed to a hospital's short-term care facility after being screened by a psychiatric emergency screening service (PESS), the trial court erred in ruling that the hospital was entitled to recover from the patient based on a theory of quasi-contract under the procedures governing a regular admission; when a mental health patient was admitted to a hospital on an emergent basis through the referral of a PESS, the provisions of the charity care regulations dealing with emergency room admissions applied,

and as the hospital did not contact the patient by phone, schedule an in-person interview with him, or send a social worker to his home to obtain the information needed to process his charity care application, it was barred from recovering from him. *Newton Med. Ctr. v. D.B., 2018 N.J. Super. LEXIS 8 (2018)*.

Term "emergency room" within the meaning of the New Jersey Charity Care Program's regulations encompasses a category of emergent admissions that incorporates emergent transfers to short-term care facilities from a psychiatric emergency screening service; this interpretation does not extend to all patients, only those involuntarily committed on an emergent basis after being assessed by an emergency screening service. *Newton Med. Ctr. v. D.B., 2018 N.J. Super. LEXIS 8 (2018)*.

N.J.A.C. 10:52-11.17

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 11. CHARITY CARE

§ 10:52-11.17 (Reserved)

History

HISTORY:

New Rule, R.2000 d.299, effective July 17, 2000.

See: *32 New Jersey Register 1123(a)*, *32 New Jersey Register 2615(a)*.

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

See: *37 New Jersey Register 436(a)*, *37 New Jersey Register 2506(a)*.

Section was "Charity care applications of patients admitted through the emergency room between January 1, 1999, and July 17, 2000".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-12.1

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

§ 10:52-12.1 Definitions

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

"Adjudication" means the processing of all submitted claims accepted by the Fiscal Agent during a monthly adjudication cycle, with the outcome being the claim is priced, denied, or processed as a void or adjustment of a previous claim. Voids and adjustments are also either priced or denied.

1. Claims included in files that are rejected during preprocessing are not adjudicated because the claims never enter the system for pricing.

2. Adjudicated claims are reported monthly to the hospital or the hospital's designated agent on the Remittance Advice.

"Adjudication cycle date" is the date on which claims are accepted for pricing by the Fiscal Agent and are adjudicated.

"Clean charity care claim" means a charity care claim that is received by the Fiscal Agent and accepted by the Fiscal Agent in accordance with electronic media procedures and is adjudicated and priced no later than two years after the date of patient discharge (inpatient) or date of service (outpatient). Claims that are denied are not clean claims. A clean charity care claim includes:

1. The name and provider number assigned by the Department of Health to each licensed hospital;

2. The name and, if available, Social Security number of the charity care eligible recipient of the services;

3. The diagnosis(es);

4. The date of service for outpatient services or dates of admission and discharge for inpatient services;

5. The services rendered and the charge for the service; and

6. The data required by the Fiscal Agent in accordance with the Fiscal Agent Billing Supplement, provided that the requirement is not in conflict with the provisions of the New Jersey Administrative Code.

"Pricing cycle" means the Fiscal Agent's charity care claims submission schedule, as described in *N.J.A.C. 10:52-12.2(c)*.

"Remittance Advice (RA)" means the hospital's account statement of activity for the most recent monthly adjudication cycle which reflects the status of all charity care claims, tracked according to a unique Internal Control Number (ICN), adjudicated by the Fiscal Agent during that cycle.

"Submission cut-off date" means the date by which claims shall be received by the Fiscal Agent to assure processing for and possible adjudication in the pricing cycle.

History

HISTORY:

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

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In paragraph 1 of definition "Clean charity care claim", deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-12.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

§ 10:52-12.2 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund

(a) This subchapter sets forth the requirements of the New Jersey State Department of Health that the provider shall adhere to when submitting a charity care claim.

(b) A charity care claim shall be submitted in accordance with the electronic media claims (EMC) manual, which is part of the Fiscal Agent Billing Supplement (see (d) below), by an approved method of electronic automated data exchange. In order for a charity care claim to be priced, it must be a clean charity care claim.

(c) The State of New Jersey uses a Fiscal Agent for the pricing of charity care claims.

1. The Department of Health will advise hospitals in December of each year of the Fiscal Agent's pricing cycle and submission cut-off dates for the following calendar year. Charity care claims shall be adjudicated monthly by the Fiscal Agent.

2. Hospitals shall submit claims at least monthly to the Fiscal Agent. Claims submitted after the submission cut-off date shall not be guaranteed to be processed for the upcoming monthly cycle. Hospitals shall be solely responsible for meeting submission cut-off deadlines.

3. Hospitals shall be solely responsible for submission of clean charity care claims in an electronic format that can be processed by the Fiscal Agent.

4. Hospitals shall be solely responsible for verifying receipt and acceptance or rejection by the Fiscal Agent of all submitted claims files.

5. The Fiscal Agent shall reject partially or in its entirety an electronic claims file containing any technical defect(s) that prevent electronic processing. The Fiscal Agent shall advise the hospital or its designated agent in writing, within 10 days of the attempted processing, that the file could not be processed. The notice shall document the reason(s) for the failure to process the electronic claims file. If the hospital designates an agent to submit its charity care claims to the Fiscal Agent, all notices from the Fiscal Agent to the hospital's designated agent shall constitute notice to the hospital.

6. The Fiscal Agent shall deny for pricing all claims that do not meet the criteria for clean charity care claims.

7. The Fiscal Agent shall provide the hospital a charity care claim remittance advice once a month, unless the hospital has failed to submit any claims capable of adjudication during the adjudication cycle. The charity care claim remittance advice shall constitute the hospital's account statement for all charity care claims adjudicated by the Fiscal Agent during the most recent adjudication cycle. The charity care claim remittance advice shall identify codes for claims on the remittance advice, both priced and unpriced. If the hospital designates an agent to submit its charity care claims to the Fiscal Agent, all notices from the Fiscal Agent to the hospital's designated agent shall constitute notice to the hospital.

8. A unique internal control number (ICN) is assigned to each charity care claim that is adjudicated by the fiscal agent. The ICN is reflected on the remittance advice. The ICN can be used to track the status of a claim.

9. All charity care claims adjudicated by the Fiscal Agent are classified as either priced or denied claims. Void and adjustment claims may also be either priced or denied.

i. Priced claims shall be processed in accordance with this subchapter. A charity care claim that is a clean charity care claim for a covered service provided to an eligible charity care recipient by an approved hospital will be priced. The status of the claim shall appear on the claim status page, or pages, of the remittance advice, along with the status of all other claims which are being priced in that cycle.

ii. Denied claims shall be processed in accordance with this subchapter. Reasons for denial of a charity care claim shall be provided on the remittance advice in the form of a code. The hospital shall have the opportunity to resubmit a denied charity care claim in a subsequent cycle, within two years of the date of service (outpatient) or date of discharge (inpatient).

iii. Void and adjustment claims will be processed and adjudicated in accordance with this subchapter. Void and negative adjustment (reduction in payment) claims may be submitted at any time. Adjustments resulting in an increased payment amount shall be submitted within two years of date of service (outpatient) or date of discharge (inpatient).

(d) In addition to information in this section about submitting claims for pricing of outpatient and inpatient charity care claims, a Fiscal Agent Billing Supplement (FAB) and an Electronic Claims Manual are included as Appendices A and B to this chapter, incorporated herein by reference. The FAB includes information regarding the following:

1. The proper completion and submission of claim forms;

2. The procedure to follow when claims are denied and returned to the provider by the Fiscal Agent during the adjudication process;

3. Third party liability verification;

4. EMC submission;

5. Remittance Advice statements for pricing of claims and adjustments of Medicare;

6. The procedure to follow when a claim is priced in error (void);

7. The procedure for inquiries about claims;

8. The procedure for ordering forms;

9. Provider services; and

10. Item by item instructions for completing the claim form and other forms.

(e) The Fiscal Agent Billing Supplement is not published in the New Jersey Administrative Code but is referenced as an Appendix to this chapter and is not a legal description of the charity care program rules. Should there be any conflict between the Fiscal Agent Billing Supplement and the applicable laws or rules governing the charity care program, the charity care rules contained in this chapter and in *N.J.A.C. 10:49* shall take precedence.

History

HISTORY:

Recodified from *N.J.A.C. 10:52-12.1* and amended by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

Rewrote the section. Former *N.J.A.C. 10:52-12.2*, Basis of pricing for charity care claims, recodified to *N.J.A.C. 10:52-12.3*.

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

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

In (d), rewrote the introductory paragraph.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a) and (c)1, deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-12.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

§ 10:52-12.3 Basis of pricing for charity care claims

(a) All hospital outpatient and inpatient charity care claims shall be priced based on the New Jersey Medicaid/NJ FamilyCare program's pricing and program policies for hospital outpatient and inpatient hospital services. (See this chapter, and, specifically, *N.J.A.C. 10:52-1.6*, Covered services (inpatient and outpatient services), and 10:52-4, Basis of Payment.)

1. Exception: Although the New Jersey Medicaid/NJ FamilyCare program reimburses dental services on a fee-for-service schedule for outpatient hospital charity care claims, dental services shall be priced based on hospital outpatient cost to charge ratio as described in *N.J.A.C. 10:52-4.3*. All other hospital outpatient services for charity care shall also be priced according to the Medicaid/NJ FamilyCare hospital outpatient methodology. (See *N.J.A.C. 10:52-4.3*.)

(b) All hospital outpatient and inpatient charity care claims pricing results shall be considered final and not subject to cost settlements or adjustments resulting from subsequent rate appeal changes when evaluating total charity care amounts.

History

HISTORY:

Amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Changed N.J.A.C. reference.

Recodified from *N.J.A.C. 10:52-12.2* by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), substituted "Medicaid/NJ FamilyCare" for "Medicaid" throughout; and in the introductory paragraph of (a), substituted ", and" for "and N.J.A.C.".

Annotations

Notes

§ 10:52-12.3 Basis of pricing for charity care claims

Chapter Notes

End of Document

N.J.A.C. 10:52-13.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

§ 10:52-13.1 Disproportionate share adjustment--general eligibility

(a) A disproportionate share hospital (DSH) shall be a hospital designated as such by the Commissioner of the Department of Human Services. At a minimum, each hospital with a Medicaid/NJ FamilyCare inpatient hospital utilization rate that is one standard deviation above the mean Medicaid/NJ FamilyCare utilization rate for hospitals receiving Medicaid/NJ FamilyCare payments in the State, and every hospital with a low-income utilization rate above 25 percent will be treated as a disproportionate share hospital.

(b) The Commissioner of the Department of Human Services may designate additional hospitals as disproportionate share hospitals if it is determined they serve a large number of low-income mentally ill or developmentally disabled clients.

(c) The Commissioner of the Department of Human Services may make additional disproportionate share payments to facilities operating under *N.J.S.A. 18A:64G-1* et. seq. providing a high level of charity and uncompensated care to low-income persons and persons with special needs.

(d) The Commissioner of the Department of Human Services may also designate a hospital as eligible for additional disproportionate share payments if it is determined that the hospital provides a high percentage of care (as defined in *N.J.A.C. 10:52-13.5*) in proportion to total operating revenue to patients with HIV, mental illness, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse. In addition, to be designated as eligible for this additional disproportionate share payment, the facility shall have a high Charity Care plus Medicaid/NJ FamilyCare utilization rate (as defined in *N.J.A.C. 10:52-13.5*).

History

HISTORY:

Amended by R.1997 d.92, effective February 18, 1997.

See: *28 N.J.R. 4698(a)*, *29 N.J.R. 80(a)*, *29 N.J.R. 600(b)*.

Substantially amended (d).

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

In (a), deleted the third sentence.

Recodified from 10:52-8.1 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (d) changed N.J.A.C. references throughout, and substituted a reference to complex neonates, HIV as a secondary diagnosis and mothers with substance abuse for a reference to neonatal complexity at the end of the first sentence.

Amended by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

In (d), deleted the last sentence.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a) and (d), substituted "Medicaid/NJ FamilyCare" for "Medicaid" throughout.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-13.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

§ 10:52-13.2 Disproportionate share hospital (DSH) payment--general

The disproportionate share adjustment shall include an adjustment amount annually determined, as to *N.J.A.C. 10:52-13.4*, by the Commissioner, Department of Health in consultation with the Commissioner, Department of Human Services and, as to *N.J.A.C. 10:52-13.3*, *13.5*, *13.6*, and *13.7* by the Commissioner, Department of Human Services based upon a determination regarding payments for charity care. The annual DSH payments shall be calculated and distributed in accordance with all applicable Federal laws and regulations.

History

HISTORY:

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: *28 N.J.R. 4115(a)*.

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: *28 N.J.R. 4115(a)*, *28 N.J.R. 4805(c)*.

Amended by R.1997 d.92, effective February 18, 1997.

See: *28 N.J.R. 4698(a)*, *29 N.J.R. 80(a)*, *29 N.J.R. 600(b)*.

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a) and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Changed N.J.A.C. references throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-13.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

§ 10:52-13.3 Eligibility and disproportionate share hospital payments for hospitals operating under *N.J.S.A. 18A:64G-1*

For facilities operating under *N.J.S.A. 18A:64G-1* et seq., the disproportionate share allocation may be increased by an amount recommended by the Office of Management and Budget which will consider the total operating cost of the facility less any third-party payments, including all other Medicaid/NJ FamilyCare payments, as well as payments from non-State sources for services provided by the hospital during the hospital's fiscal year.

History

HISTORY:

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: *28 N.J.R. 4115(a)*.

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: *28 N.J.R. 4115(a)*, *28 N.J.R. 4805(c)*.

Amended by R.1997 d.92, effective February 18, 1997.

See: *28 N.J.R. 4698(a)*, *29 N.J.R. 80(a)*, *29 N.J.R. 600(b)*.

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a)1 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Substituted a reference to disproportionate share allocations for a reference to disproportionate share adjustments determined by the Essential Health Services.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Substituted "third-party" for "third party" and "Medicaid/NJ FamilyCare" for "Medicaid".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-13.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

§ 10:52-13.4 Eligibility for disproportionate share hospital payments from the Charity Care Component of the Health Care Subsidy Fund

(a) The recommendation from the Department of Health shall be calculated in the following manner pursuant to *N.J.S.A. 26:2H-18*.

1. The determination of the value of the Charity Care Component of the Health Care Subsidy Fund shall be calculated in the following manner:

i. The Department of Health shall use the results of the charity care audit conducted as its definition of charity care incurred by all hospitals.

ii. The New Jersey Department of Health shall report the results of its audit of New Jersey acute care hospital's charity care that was conducted in accordance with N.J.A.C. 10:52-11 to the Division of Medical Assistance and Health Services.

(1) For purposes of determining annual charity care costs, the criteria in N.J.A.C. 10:52-11 shall not apply to a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction pursuant to *N.J.S.A. 30:4-1* et seq. A patient so found shall qualify for 100 percent charity care coverage. Hospitals with patients who qualify under this provision shall include the appropriate documentation from the court in the patient's file for audit.

(b) All charity care accounts shall be valued in accordance with the Medicaid methodology as follows:

1. For inpatient accounts, the New Jersey Department of Health and the New Jersey Department of Human Services shall value each account at the rate Medicaid would have reimbursed hospitals for the services(s).

2. For outpatient accounts, outpatient charity care accounts submitted during the calendar year will be valued as follows: annual outpatient charity care charges multiplied by the ratio of the annual outpatient Medicaid/NJ FamilyCare interim payments to the annual outpatient Medicaid charges associated with paid claims. This Medicaid/NJ FamilyCare outpatient payment-to-charge ratio excludes billings for HealthStart and dental services.

3. Disproportionate share adjustments and final rate settlements for the service period shall not be taken into account for the recognition of charity care costs.

(c) For eligible hospitals, charity care subsidy amounts are determined as follows:

1. Eligible hospitals annual charity care subsidy amount is equal to charity care costs as determined by the audit and valued at Medicaid/NJ FamilyCare rates.

2. In no instances shall payments made during a calendar year exceed the preceding years audited and Medicaid/NJ FamilyCare rate valued amounts inflated by TEFRA rates used in the hospital rate setting system.

3. Any overpayments which result from interim payments exceeding the audited payment levels shall be recovered by offsetting all Medicaid/NJ FamilyCare payments.

(d) For periods in which the data source excludes Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) in the Medicaid/NJ FamilyCare rate, the Medicaid/NJ FamilyCare rate shall be adjusted by hospital-specific GME and IME add-ons. Effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. These GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid/NJ FamilyCare rate adjustments. For the purpose of pricing charity care claims under this section, unless otherwise indicated, the Medicaid/NJ FamilyCare rate shall be defined as the Medicaid/NJ FamilyCare rate in effect on the date of discharge. The add-ons shall be calculated as follows:

1. The GME add-on shall be calculated as follows:

i. For charity care payments made after State Fiscal Year 1999, the charity care GME add-on shall be calculated based on the charity care share of the teaching hospital's aggregate approved GME amount from Worksheet E-3 Part IV as reported on the most recent submitted Medicare cost report as of February 1 of each year preceding the distribution year. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, after desk audit.

2. The IME add-on shall be calculated as follows:

i. For charity care payments made after State Fiscal Year 1999, the IME add-on shall be calculated based on Medicare's IME formula, at *42 C.F.R. 412.105*, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report as of February 1 of each year preceding the distribution year. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

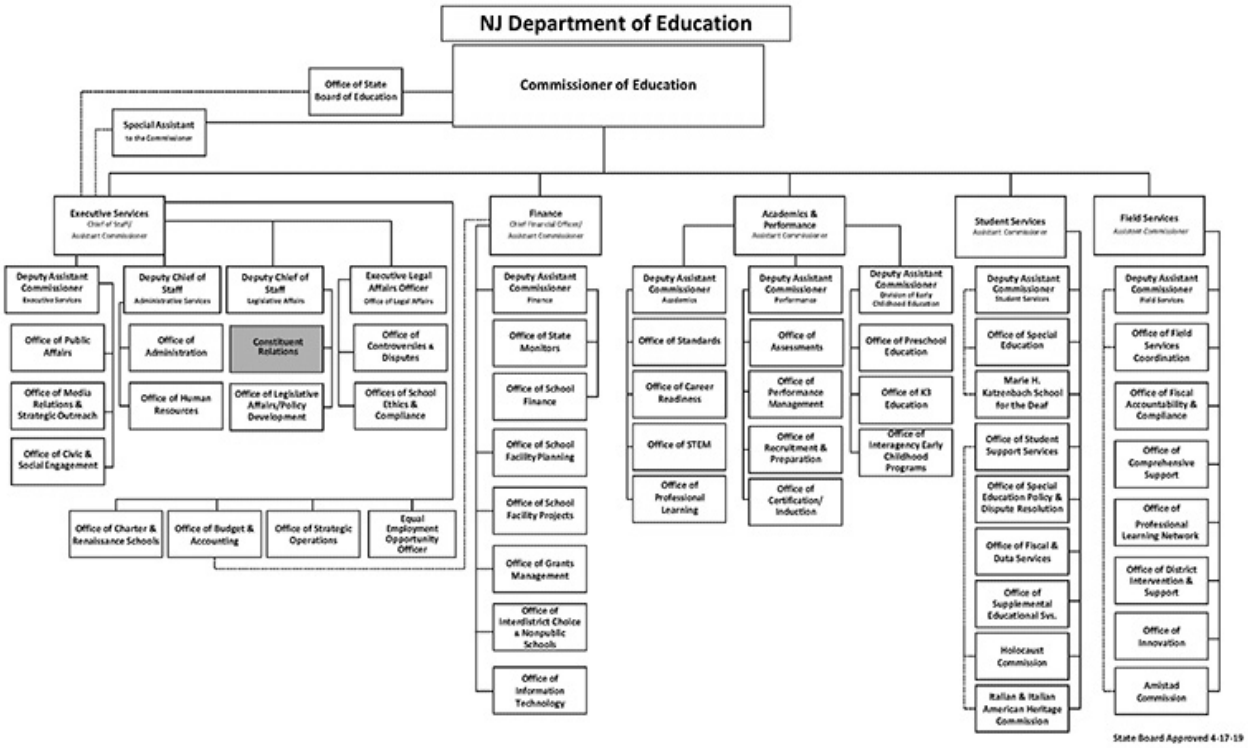
(e) As provided in *N.J.S.A. 26:2H-18.59e*, the charity care subsidy shall be determined according to the following methodology:

1. The hospital-specific "documented charity care" shall be calculated from the dollar amount of charity care provided by the hospital that is submitted to the charity care fiscal intermediary and valued at the same rate paid to that hospital by the Medicaid/NJ FamilyCare program. A sample of the claims submitted by the hospital to the fiscal intermediary shall be subject to an audit conducted pursuant to charity care eligibility criteria. For each fiscal year, documented charity care claims shall be equal to the Medicaid/NJ FamilyCare-priced amounts of charity care claims submitted to the fiscal intermediary for the most recent calendar year, adjusted as necessary to reflect the audit results, as well as GME/IME, in accordance with (d) above.

2. The hospital-specific "operating margin" shall be calculated using data from the three most current years' New Jersey Hospital Cost Reports (see *N.J.A.C. 8:31B-3.16*) and shall be equal to income from operations minus charity care subsidies divided by total operating revenue minus charity care subsidies. After calculating each hospital's operating margin, the Department shall determine the Statewide median operating margin.

3. The hospital-specific "profitability factor" shall be determined annually as follows. Those hospitals that are equal to or below the Statewide median operating margin shall be assigned a profitability factor

of "1." For those hospitals that are above the Statewide median operating margin, the profitability factor shall be equal to:



5. The hospital-specific "revenue from private payers" shall be equal to the sum of the gross revenues reported to the Department in the hospital's most recently available New Jersey Hospital Cost Report (see *N.J.A.C. 8:31B-3.16*) for all non-governmental, or private third party payers, including, but not limited to, Blue Cross and Blue Shield plans, commercial insurers and the non-governmental, or private accounts of managed care organizations. Gross revenue derived from governmental accounts of managed care organizations from the Medicare, Medicaid, NJ FamilyCare (including NJ FamilyCare-Children's Program) programs, will not be included in the category of "revenue from private payers."

6. The hospital-specific "payer mix factor" shall be equal to a hospital's adjusted charity care divided by its revenue from private payers.

7. The "Statewide target payer mix factor" shall be equal to the lowest payer mix factor to which all hospitals receiving charity care subsidies can be reduced by spending all available charity care subsidy funding for that year.

8. The hospital-specific "income from operations" shall be defined by the Department of Health (DOH) in accordance with financial reporting requirements established pursuant to *N.J.A.C. 8:31B-3.3*.

9. The hospital-specific "total operating revenue" shall be defined by the DOH in accordance with financial reporting requirements established pursuant to *N.J.A.C. 8:31B-3.3*.

10. Charity care subsidy payments shall be based upon hospital-specific documented charity care.

11. If the Statewide total of adjusted charity care is less than available charity care funding, a hospital's charity care subsidy shall equal its adjusted charity care.

12. If the Statewide total of adjusted charity care is greater than available charity care funding, then the hospital-specific charity care subsidy shall be determined by allocating available charity care funds so

as to equalize hospital-specific payer mix factors to the Statewide target payer mix factor. Those hospitals with a payer mix factor greater than the Statewide target payer mix factor shall be eligible to receive a subsidy sufficient to reduce their factor to that Statewide level. Those hospitals with a payer mix factor that is equal to or less than the Statewide target payer mix factor shall not be eligible to receive a subsidy.

(f) The charity care subsidy payment schedule for the fiscal year shall be implemented the first month after the Department distributes the schedule to all disproportionate share hospitals. The charity care subsidy payment schedule constitutes advice to the hospitals of the allocation of charity care subsidies available for that fiscal year. Hospitals shall receive the charity care subsidy payments in 12 monthly installments.

1. A hospital which suspects that the charity care subsidy payment schedule reflects a calculation error shall notify the Commissioner of DOH in writing of the suspected calculation error within 15 days of issuance of the schedule. Failure by the charity care subsidy payment schedule to reflect specific charity care claims or hospital cost report data, including corrections, shall not constitute a calculation error. If, upon review, the Commissioner determines that a calculation error did occur, a revised charity care subsidy payment schedule shall be issued.

2. A notice by a hospital of an intent to appeal the amount of its charity care subsidy indicated on the charity care subsidy payment schedule, for reasons other than a calculation error, shall be submitted in writing to the Commissioner within 15 calendar days of issuance of the charity care subsidy payment schedule. Within 30 calendar days of issuance of the charity care subsidy payment schedule, the hospital shall submit to the Commissioner two copies of its appeal, describing in detail the basis of its appeal of the charity care subsidy payment schedule. Appeals shall not include new submissions pertaining to claims and/or cost report data that was not previously submitted in accordance with the time frames and procedures specified in N.J.A.C. 10:52-11 and 12 and *N.J.A.C. 8:31B*. The appeal document shall list all factual and legal issues, including citation to the applicable provisions of the charity care rules, and shall include written documentation supporting each appeal issue. If the hospital fails to submit the required documentation within the prescribed time frame, such hospital shall have forfeited its right of appeal and the charity care subsidy payment schedule shall be deemed to have been accepted by the hospital.

3. The Commissioner of the Department of Health shall schedule a detailed review to be conducted by the Department with the hospital not more than 45 calendar days following receipt of the appeal document. If the hospital fails to appear on the established date, it shall have forfeited its right of appeal and the charity care subsidy payment schedule shall be deemed to have been accepted by the hospital.

4. At the detailed review with the hospital, the Department representative shall indicate whether the appeal is supported by sufficient documentation to permit a resolution, and the hospital shall be permitted 10 calendar days after the date of the review in which to submit the additional documentation which the Department indicates is needed for resolution. Following receipt of this documentation, the Department shall neither request nor require further documentation. The Commissioner shall give consideration only to documentation submitted pursuant to the deadlines set forth in this section in deciding upon any of the hospital's appeal issues.

5. Within 30 calendar days of the review with the hospital, the Commissioner will render detailed findings on the factual and legal issues concerning whether an adjustment to the Charity Care Subsidy Payment Schedule is warranted. The Commissioner's decision shall constitute the final agency adjudication.

History

HISTORY:

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: *28 N.J.R. 4115(a)*.

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: *28 N.J.R. 4115(a)*, *28 N.J.R. 4805(c)*.

Amended by R.1997 d.92, effective February 18, 1997.

See: *28 N.J.R. 4698(a)*, *29 N.J.R. 80(a)*, *29 N.J.R. 600(b)*.

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a)2 and 3 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Rewrote the section.

Amended by R.2001 d.301, effective August 20, 2001.

See: *33 N.J.R. 2062(a)*, *33 N.J.R. 2811(a)*.

Added (e).

Amended by R.2003 d.485, effective December 15, 2003.

See: *35 N.J.R. 509(a)*, *35 N.J.R. 5568(a)*.

In (b), substituted "in accordance with the Medicaid methodology" for "at the Medicaid rate" in the introductory paragraph, and substituted "submitted" for "written-off" and inserted "interim" preceding "payments" in 2; in (e), inserted ", as well as GME/IME, in accordance with (d) above" following "audit results" in 1 and inserted the N.J.A.C. references in 2 and 5; added (f).

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

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

In (c), deleted former 2 and recodified former 3 and 4 as 2 and 3.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

Case Notes

New Jersey Division of Medical Assistance and Health Services' calculation method with regard to determining whether a hospital has sustained a marginal loss pursuant to *N.J.A.C. 10:52-9.1(b)*2 as the result of providing inpatient services to Medicaid and NJ FamilyCare-Plan A recipients properly utilizes Disproportionate Share Hospitals payments as revenue in calculating whether the hospital has sustained a marginal loss. The Division's use of Medicaid costs contained in hospital Medicare cost reports was also upheld with regard to the Division making its calculations. *In re HOSPITALS' PETITIONS, 383 N.J. Super. 219, 891 A.2d 641, 2006 N.J. Super. LEXIS 42 (2006)*.

N.J.A.C. 10:52-13.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

§ 10:52-13.5 Eligibility for and payment of Hospital Relief Subsidy Fund DSH

(a) Hospitals eligible for additional disproportionate share payments may receive an additional payment determined by the Commissioner of the Department of Human Services from the Hospital Relief Subsidy Fund. This additional payment shall be based upon the facility's percentage of clients with HIV, mental health, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse.

1. Effective for periods after State Fiscal Year 1999, payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the most recent calendar year hospital data available as of February 1 of each State fiscal year preceding the distribution year. For the purpose of pricing the problem billed cases listed at (a)1ii(1) below effective on or after July 6, 1998, the Medicaid/NJ FamilyCare rate shall be defined as the rate in effect as of February 1 of each State fiscal year preceding the distribution year. Effective for payments on or after July 6, 1998, this payment shall no longer be distributed over a Calendar Year. Instead, it shall be distributed over the State Fiscal Year, July through June.

i. For purposes of determining which hospitals are eligible for payment from the HRSF, a hospital shall satisfy both of the two following independent criteria:

(1) The hospital's cases for the seven categories listed at (a)1ii(1) below, priced at the Medicaid/NJ FamilyCare rate, divided by the hospital's Total Operating Revenue, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey Hospitals receiving Medicaid/NJ FamilyCare payments. For periods in which the data source excludes GME and IME in the rate, the Medicaid rate shall be adjusted by a hospital-specific GME and IME add-ons. The hospital-specific GME and IME add-ons shall be calculated as defined in (a)1iv below; and

(2) The hospital's charity care days plus the hospital's Medicaid/NJ FamilyCare-Plan A days, divided by the hospital's total days, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey hospitals receiving Medicaid/NJ FamilyCare-Plan A payments. For payments distributed in State Fiscal Years after State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid FamilyCare-Plan A managed care days if the data is available by February 1 prior to the State fiscal year of distribution.

ii. The subsidy shall be an amount allocated by the Commissioner during the fiscal year for this purpose and shall be distributed in the following manner:

(1) The payments for admissions for the following categories are taken from the same calendar year hospital data as defined in (a)4i above maintained by the New Jersey Department of Health:

(A) HIV (MDC 24);

(B) Mental Health (MDC 19);

(C) Substance Abuse (MDC 20);

(D) Complex Neonates (DRG 600 through 618, 622, 623, 626, or 627);

(E) Tuberculosis as a major or minor diagnosis (ICD-10-CM; 010.0 through 018.9);

(F) Mothers with substance abuse (MDC 14 with the following codes: (ICD-10-CM; 6483, 6555, 304, and 305); and

(G) HIV as a secondary diagnosis (excluding MDC 24; including ICD-10-CM; 0420 through 0422, 0429 through 0433, 0439, 0440, and 0449).

iii. The funding for the subsidy shall be distributed among eligible facilities based upon the hospital's percentage of payments, priced at the Medicaid/NJ FamilyCare rate, including the relevant GME and IME add-ons as defined in (a)1iv below, for patient with the categories in (a)1ii(1) above as a percentage of all payments, priced at the Medicaid/NJ FamilyCare rate, including the relevant GME and IME add-ons as defined in (a)1iv below, for patients in these categories in eligible hospitals.

iv. For periods in which the data source excludes GME and IME costs in the Medicaid/NJ FamilyCare-Plan A fee-for-service rate, the rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified in this section, effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid/NJ FamilyCare-Plan A rate. The add-ons shall be calculated as follows:

(1) A hospital-specific GME add-on shall be calculated based on the hospital-specific GME per discharge multiplied by the number of cases of the categories defined in (a)1ii(1) above. The hospital-specific GME per discharge shall be calculated on the inpatient share of the aggregate approved GME amount from Worksheet E-3 Part IV of the Medicare submitted cost report divided by the hospital-specific total hospital discharges from Worksheet S-3 Part I of the Medicare submitted cost report.

(2) The hospital-specific IME add-on shall be calculated based on Medicare's IME formula, at *42 CFR 412.105*, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the number of cases of the categories defined in (a)1ii(1) above, priced at the current available Medicaid/NJ FamilyCare inpatient rates. The components of the IME formula, IME intern and resident FTEs, and maintained beds shall be taken from the Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the Medicare submitted cost report used in the calculation.

History

HISTORY:

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: *28 N.J.R. 4115(a)*.

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: *28 N.J.R. 4115(a)*, *28 N.J.R. 4805(c)*.

Amended by R.1997 d.92, effective February 18, 1997.

See: *28 N.J.R. 4698(a)*, *29 N.J.R. 80(a)*, *29 N.J.R. 600(b)*.

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a)4 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Made internal designation and internal reference changes throughout.

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

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

In (a), substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

End of Document

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

§ 10:52-13.6 Eligibility and payment for DSH funding from the Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients

(a) Disproportionate Share Hospitals which service a large number of low-income mentally ill or developmentally disabled clients may also be eligible to receive increased disproportionate share payments. The amount of payment to be made to facilities which serve a large number of mentally ill low-income clients will be based upon recommendation by the Division of Mental Health and Addiction Services (DMHAS) within the Department of Human Services to the Commissioner of the Department of Human Services. This recommendation will identify hospitals essential to preserve the fragile network of mental health providers in the State. The Division of Developmental Disabilities may also recommend an additional payment to facilities that serve a large number of developmentally disabled clients. These additional payments will assure that these low-income and special needs clients continue to have access to critical care.

1. The Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients shall be an amount allocated by the Commissioner during the fiscal year for this purpose. It shall be distributed in the following manner:

i. Hospitals who receive funding from the Hospital Relief Subsidy Fund shall only be eligible for a payment from this fund if recognized by the Division of Mental Health and Addiction Services as a Short-Term Care Facility (STCF) or a Child Community Inpatient Serviced STCF and CCIS shall be based upon its distribution of beds for these services times a projection of the cost of providing the service in a state facility. Any hospital adding these beds will be eligible for payments from this fund. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year but may be redistributed on a quarterly basis as new beds are added or removed from service, at the discretion of DMHAS.

ii. Hospitals who are not a STCF or CCIS, but which are under contract with the Division of Mental Health and Addiction Services shall receive an allocation of funds based upon the percentage of services provided by the hospital as a percentage of all services provided by all hospitals. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year but may be redistributed on a quarterly basis as new beds are added or removed from service, at the discretion of DMHAS.

History

HISTORY:

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: *28 N.J.R. 4115(a)*.

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: *28 N.J.R. 4115(a)*, *28 N.J.R. 4805(c)*.

Amended by R.1997 d.92, effective February 18, 1997.

See: *28 N.J.R. 4698(a)*, *29 N.J.R. 80(a)*, *29 N.J.R. 600(b)*.

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).

See: *29 N.J.R. 3227(a)*, *29 N.J.R. 5325(a)*.

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

See: *30 N.J.R. 1260(a)*, *30 N.J.R. 2486(b)*.

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a)5 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

Made internal designation changes throughout.

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

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

In (a), inserted "(DMHS)" following "Division of Mental Health Services" in the introductory paragraph, substituted "STCF" for "STF" preceding "and CCIS" and rewrote the last sentence in 1i, and rewrote the last sentence in 1ii.

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Inserted "and Addiction" and substituted "DMHAS" for "DMHS" throughout; and in (a)1i, substituted "Short-Term" for "Short Term" and "Serviced STCF" for "ServicedSTCF".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-13.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

§ 10:52-13.7 Calculation and distribution of disproportionate share hospital (DSH) payments as a result of a hospital closure; purpose, and procedure

(a) The purpose of this rule is to provide a procedure to redistribute disproportionate share hospital (DSH) payments to provide for the patients who would have been served by a closed general hospital, had the hospital remained open. Hospital closure is defined as cessation of operations as a general hospital facility. When a hospital closes, DSH payments to the closed hospital will immediately cease. The DSH payments that would have gone to that hospital, had that hospital not closed, shall be reallocated and distributed to eligible hospitals, in accordance with Federal and State laws, rules and regulations. The eligible hospitals that are serving or are expected to serve the patients who would have gone to the closed hospital will receive the closed hospital's remaining allocation for the State fiscal year in which the hospital closed. This rule shall be applied to specify the eligible hospitals and the calculation and distribution of the closed hospital's DSH payments. Subsections (b), (c) and (d) below address the charity care subsidy allocated pursuant to *N.J.S.A. 26:2H-18.59(e)*, and any supplemental charity care subsidy allocated pursuant to any appropriations act that may provide for supplemental charity care subsidies; subsection (e) below addresses the Hospital Relief Subsidy Fund.

(b) To be eligible for a portion of the closed hospital's charity care allocation and/or supplemental charity care allocation, a hospital shall satisfy all three of the following criteria:

1. The hospital shall have received a charity care subsidy allocation, under the methodology set forth in *N.J.S.A. 26:2H-18.59e*, and/or a supplemental charity care subsidy allocation, under the methodology set forth in any appropriations act that may provide for supplemental charity care subsidies, during the State Fiscal Year in which the closed hospital ceased operations as a general hospital;

2. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined, based on the most recent available complete calendar year UB data maintained by the Department of Health, as follows:

i. Rank zip codes from highest to lowest, based on the percentage of total admissions drawn from each zip code by the closed hospital; and

ii. Include the ranked zip codes in the closed hospital's market area (beginning with the highest-ranked zip code) until the percentage of admissions, when added together, constitutes 75 percent of the closed hospital's total admissions; and

3. The hospital shall demonstrate that it has a market share of 25 percent or more of admissions from the market area that the closed hospital served, as defined in (b)2 above. This determination shall likewise be made based on the most recent available complete calendar year UB data maintained by DOH, but the closed hospital's UB data will not be included in making this determination.

(c) The available charity care and/or supplemental charity care funds to be reallocated, with respect to the State fiscal year in which the hospital closed, shall be distributed among eligible hospitals based upon each eligible hospital's market share of admissions as a percentage of the market share of admissions of all eligible hospitals, as determined from the results of the calculations in (b)3 above.

(d) In each year after the hospital closed in which the source hospital data precedes the year of closure and includes at least six months of hospital charity care claims data, a charity care and/or supplemental charity care allocation that would have gone to the closed hospital shall be initially calculated. Then the reallocation of the closed hospital's calculated charity care and/or supplemental charity care allocation shall be calculated and distributed to eligible hospitals, using the methodology set forth in (b) above to identify eligible hospitals. The available charity care and/or supplemental charity care funds to be reallocated under this subsection shall be distributed among eligible hospitals based upon each eligible hospital's market share of admissions as a percentage of the market share of admissions of all eligible hospitals, as determined from the results of the calculations pursuant to (b) above.

(e) In each year after the hospital closed in which the source hospital data precedes the year of closure and includes at least six months of hospital data, a Hospital Relief Subsidy Fund (HRSF) allocation that would have gone to the closed hospital shall be initially calculated. Then the reallocation of the closed hospital's calculated HRSF allocation shall be calculated and distributed to eligible DSHs using the same data as was used for the original allocation, with the exception of market share admission data, which shall be taken from the most recent available UB data in the following manner:

1. To be eligible to receive a portion of the closed hospital's HRSF allocation a hospital shall satisfy all three of the following independent criteria:

i. The hospital shall have received a HRSF allocation, under the methodology set forth in *N.J.A.C. 10:52-13.5*, during the State fiscal year in which the closed hospital ceased operations as a general hospital;

ii. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined as defined in (b)2 above; and

iii. The hospital shall have a market share of 25 percent or more of problem-billed admissions. The market share problem-billed admissions shall be based on the number of admissions from the same market area, identified by zip code that the closed hospital served as defined in (e)1ii above, for the problem-billed categories specified in *N.J.A.C. 10:52-13.5(a)*1i(2) and (a)1ii(1).

2. The available HRSF payments to be reallocated shall be distributed among eligible hospitals based upon each eligible hospital's market share of problem-billed admissions as a percentage of the market share of problem-billed admissions of all eligible hospitals, as determined from the results of the calculations in (e)1iii above. The reallocated funds shall be distributed on a monthly basis.

(f) Notwithstanding any other provision of this rule, if the Commissioner of Health and the Commissioner of Human Services agree that, in the case of closure of a hospital eligible to receive DSH funds, maintaining beneficiary access to health care services requires an alternative distribution of a closed hospital's DSH funds, they will do so in accordance with this subsection. Factors the Commissioners will consider in determining whether an alternative distribution will be made shall include, but shall not be limited to, the following:

1. Maintenance of continued timely access to hospital-based services for persons eligible to participate in the New Jersey Hospital Care Payment Assistance Program and/or persons receiving services in the Hospital Relief Subsidy Fund categories; or

2. Continued operation in the same or adjoining municipality as the closed hospital of an acute care hospital, eligible to receive Disproportionate Share payments, belonging to the same system as the closed hospital and serving substantially the same eligible population.

History

HISTORY:

New Rule, R.1998 d.60, effective January 20, 1998.

See: *29 N.J.R. 4376(a)*, *30 N.J.R. 388(a)*.

Recodified from 10:52-8.3 and amended by R.2000 d.29, effective January 18, 2000.

See: *31 N.J.R. 3151(a)*, *32 N.J.R. 276(a)*.

In (c)1ii, changed N.J.A.C. reference.

Amended by R.2001 d.302, effective August 20, 2001.

See: *33 N.J.R. 2064(a)*, *33 N.J.R. 2812(a)*.

Rewrote the section.

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In (e)1iii, substituted "(e)1ii" for "(d)1ii" and "*N.J.A.C. 10:52-13.5(a)*1i(2) and (a)1ii(1)" for "*N.J.A.C. 10:52-8.2(a)*4i(2)(A)"; and in (e)2, substituted "(e)1iii" for "(d)1iii".

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Calculation and distribution of disproportionate share hospital (DSH) payments as a result of a hospital closure; purpose and procedure". In the introductory paragraph of (b)2, deleted "and Senior Services (DHSS)" following "Health"; in (b)3, substituted "DOH" for "DHSS"; and in the introductory paragraph of (f), deleted "and Senior Services" following "Health".

Annotations

Notes

Chapter Notes

Case Notes

If a hospital charity care subsidy must be reallocated due to the hospital's unanticipated closure, the Commissioner of the New Jersey Department of Health and Senior Services may employ the alternative distribution methodology authorized in *N.J.A.C. 10:52-13.7(f)* in order to maintain beneficiary access to health care services in the affected community. *In re Reallocation of PBI Reg'l Med. Center's SFY 2007 Charity Care Subsidy, 406 N.J. Super. 629, 968 A.2d 1217, 2009 N.J. Super. LEXIS 95 (2009)*.

New Jersey Department of Health and Senior Services properly applied *N.J.A.C. 10:52-13.7(f)* in reallocating the hospital charity care subsidy of a closed facility to respondent hospital, as it gave great weight to respondent's acquisition of, and relocation to, the closed facility, and its willingness to serve the affected population, virtually

without interruption. Further, the New Jersey Department of Health and Senior Services New Jersey Division of Medical Assistance and Health Services agreed with the reallocations, as required by § 10:52-13.7(f). *In re Reallocation of PBI Reg'l Med. Center's SFY 2007 Charity Care Subsidy, 406 N.J. Super. 629, 968 A.2d 1217, 2009 N.J. Super. LEXIS 95 (2009)*.

End of Document

N.J.A.C. 10:52-14.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.1 Effective date

(a) Effective for inpatient services with discharge dates on or after August 3, 2009, general acute care hospitals will be paid in accordance with the New Jersey Medicaid Diagnosis Related Groups (DRG) Reimbursement System described in this subchapter.

(b) If the initial rate year is a partial year, all rate setting components used to calculate inpatient reimbursement delineated below will remain the same for the second rate year, except that the final rates will be increased by the economic factor applicable to that rate year as described in *N.J.A.C. 10:52-14.6(c)*. For the third and subsequent rate years, the Statewide base rate will not change until rebasing occurs as explained in *N.J.A.C. 10:52-14.6(e)*, add-on amounts will be calculated annually in accordance with *N.J.A.C. 10:52-14.7*, and the DRG weights will not change until recalibration occurs as delineated in *N.J.A.C. 10:52-14.3*.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-14.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.2 Definitions

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

"Add-on amount" means an amount, calculated as a percentage of the Statewide base rate, which is added to the Statewide base rate, and which is determined on a hospital-specific basis using criteria established by the Division that recognizes the additional costs associated with treating a high volume of Medicaid and other low income patients.

"Delegated" means a Quality Improvement Organization's process by which hospitals are authorized to have in-house medical staff conduct utilization review. A delegated hospital would be subject to oversight by the QIO for compliance and continued authority.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, procedures, age, sex and discharge status.

"DRG weight" means the factor derived by measuring the relative weight of the Statewide average cost of a specific DRG to the Statewide average cost for all DRGs for the purpose of calculating the payment for that specific DRG.

"Final rate" means a hospital's inpatient rate per case, which includes the Statewide base rate and the hospital's add-on amounts, if applicable, for a given rate year.

"Non-delegated" means the Quality Improvement Organization retains responsibility to perform all of the utilization review activities in a hospital.

"Quality Improvement Organization" or "QIO" means an organization, which is composed of or governed by active physicians, and other professionals where appropriate, who are representative of the active physicians in the area in which the review mechanism operates and which is organized in a manner that insures professional competence in the review of services; formerly known as a peer review organization or a utilization review organization.

"Rebasing" means setting the Statewide base rate using a more current year's claim payment data.

"Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

"Statewide base rate" means a rate per case, which applies to all general acute care hospitals based on the total Medicaid inpatient fee-for-service payment amount estimated for a given rate year.

"Utilization review" means:

1. A review of medical necessity and/or appropriateness conducted during a patient's hospitalization, consisting of admission and continued stay certification; or

2. A medical record review performed after a patient has been discharged.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-14.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.3 Calculation of the DRG weights

(a) A Statewide relative weight for each DRG was developed using the most recent available audited Medicare cost report data and Medicaid/NJ FamilyCare paid claims data for the same year. The cost data used excludes direct and indirect medical education costs. In the initial rate year, 2003 audited Medicare cost report data and 2003 Medicaid/NJ FamilyCare claim data were used to develop the DRG weights.

(b) Charges from the Medicaid/NJ FamilyCare claims were converted to cost by multiplying the routine cost center per diem costs from the Medicare cost reports times the number of routine days from the Medicaid/NJ FamilyCare claims using a hospital specific crosswalk between revenue codes and hospital cost centers, and multiplying the ancillary cost center cost-to-charge ratios from the Medicare cost reports times the ancillary charges from the Medicaid/NJ FamilyCare claims using a hospital specific crosswalk between revenue codes and hospital cost centers.

(c) The calculated routine and ancillary costs were aggregated by DRG and were used to develop total Statewide costs for each DRG.

(d) The formula used to calculate a DRG weight is as follows: the Statewide average cost per inlier case for a specific DRG divided by the Statewide average cost per inlier case for all DRGs.

(e) DRGs that did not have sufficient Medicaid/NJ FamilyCare claim volume to develop a statistically valid weight using the DRG weight setting methodology in (d) above had a weight derived from additional sources. For these DRGs, charity care claim volume was added to the Medicaid/NJ FamilyCare claim volume using the methodology in (d) above to establish a stable DRG weight. In cases where using this secondary data set did not yield a stable DRG weight, the normalized DRG weight from the corresponding New York AP DRG Grouper was used.

(f) An annual inflation factor was used to calculate inflation of routine and ancillary cost data. The inflation factor used was the excluded hospital market basket percentage increase, which is used by the Center for Medicare and Medicaid Services (CMS) for hospitals excluded from its Inpatient Prospective Payment System (IPPS), and is published in the Federal Register annually by CMS. The excluded hospital inflation factor has also been referred to as the economic factor recognized under the CMS Tax Equity and Fiscal Responsibility Act, Pub.L. 97-248, (TEFRA) target limitations.

1. Routine costs were inflated from the midpoint of the provider's cost report period to the midpoint of the rate year.

2. Ancillary costs were inflated from the last date of services provided to the midpoint of the rate year.

(g) Recalibration is the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

(h) Recalibration of the DRG weights may be done to adopt the most current Grouper version available, or may be done to use more current claims and cost report data, or both. DRG weights will be recalibrated at the discretion of the Division with the approval of the Commissioner of the Department of Human Services.

(i) The DRG weight is multiplied by the hospital's final rate, as described in *N.J.A.C. 10:52-14.6*, in order to determine DRG reimbursement.

History

HISTORY:

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), (b), and (e), substituted "Medicaid/NJ FamilyCare" for "Medicaid" throughout.

Annotations

Notes

Chapter Notes

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N.J.A.C. 10:52-14.4

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.4 List of DRG weights

(a) Initial DRG weights used to calculate reimbursement amounts for inpatient hospital services under this subchapter are as follows:

DRG	Description	DRG WEIGHTS
001	Craniotomy Age >17 W CC	3.2119
002	Craniotomy Age >17 W/O CC	2.7378
006	Carpal Tunnel Release	0.6633
007	Periph & Cranial Nerve & Other Nerv Syst Proc W CC	2.3212
008	Periph & Cranial Nerve & Other Nerv Syst Proc W/O CC	1.4428
009	Spinal Disorders & Injuries	1.5828
010	Nervous System Neoplasms W CC	1.2829
011	Nervous System Neoplasms W/O CC	1.2829
012	Degenerative Nervous System Disorders	1.0623
013	Multiple Sclerosis & Cerebellar Ataxia	1.0800
014	Stroke With Infarct	1.4805
015	Nonspecific CVA & Precerebral Occlusion W/O Infarct	0.9027
016	Nonspecific Cerebrovascular Disorders W CC	1.8880
017	Nonspecific Cerebrovascular Disorders W/O CC	0.9870
018	Cranial & Peripheral Nerve Disorders W CC	1.2094
019	Cranial & Peripheral Nerve Disorders W/O CC	0.7888
020	Nervous System Infection Except Viral Meningitis	2.0891
021	Viral Meningitis	0.7901

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
022	Hypertensive Encephalopathy	1.0677
023	Nontraumatic Stupor & Coma	0.8133
024	Seizure & Headache Age >17 W CC	0.7922
025	Seizure & Headache Age >17 W/O CC	0.6931
034	Other Disorders Of Nervous System W CC	0.7574
035	Other Disorders Of Nervous System W/O CC	0.7574
036	Retinal Procedures	0.9625
037	Orbital Procedures	1.0429
038	Primary Iris Procedures	0.6729
039	Lens Procedures With Or Without Vitrectomy	0.8409
040	Extraocular Procedures Except Orbit Age >17	0.6970
041	Extraocular Procedures Except Orbit Age <18	0.6444
042	Intraocular Procedures Except Retina, Iris & Lens	0.8700
043	Hyphema	0.6383
044	Acute Major Eye Infections	0.4071
045	Neurological Eye Disorders	0.7626
046	Other Disorders Of The Eye Age >17 W CC	0.7899
047	Other Disorders Of The Eye Age >17 W/O CC	0.5328
048	Other Disorders Of The Eye Age <18	0.6672
049	Major Head & Neck Procedures Except For Malignancy	2.0797
050	Sialoadenectomy	0.9585
051	Salivary Gland Procedures Except Sialoadenectomy	0.8633
052	Cleft Lip & Palate Repair	0.6552
053	Sinus & Mastoid Procedures Age >17	0.7550
054	Sinus & Mastoid Procedures Age <18	0.9076
055	Miscellaneous Ear, Nose & Throat Procedures	0.9325
056	Rhinoplasty	0.7115
057	T&a Proc,exc Tonsillect &/or Adenoidect Only,age >17	0.5500
058	T&a Proc,exc Tonsillect &/or Adenoidect Only,age <18	0.6663
059	Tonsillectomy &/or Adenoidectomy Only, Age >17	0.4575
060	Tonsillectomy &/or Adenoidectomy Only, Age <18	0.5894

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
061	Myringotomy W Tube Insertion Age >17	0.7150
062	Myringotomy W Tube Insertion Age <18	0.5835
063	Other Ear, Nose, Mouth & Throat O.R. Procedures	1.0437
064	Ear, Nose, Mouth & Throat Malignancy	1.0927
065	Dysequilibrium	0.6643
066	Epistaxis	0.8008
067	Epiglottitis	0.8089
068	Otitis Media & Uri Age >17 W CC	0.5855
069	Otitis Media & Uri Age >17 W/O CC	0.4129
070	Otitis Media & Uri Age <18	0.3632
071	Laryngotracheitis	0.3000
072	Nasal Trauma & Deformity	0.5475
073	Other Ear, Nose, Mouth & Throat Diagnoses Age >17	0.7211
074	Other Ear, Nose, Mouth & Throat Diagnoses Age <18	0.5273
075	Major Chest Procedures	2.8947
076	Other Resp System O.R. Procedures W CC	2.5834
077	Other Resp System O.R. Procedures W/O CC	1.4352
078	Pulmonary Embolism	1.6340
079	Respiratory Infections & Inflammations Age >17 W CC	1.5052
080	Respiratory Infections & Inflammations Age >17 W/O CC	1.1537
082	Respiratory Neoplasms	1.5074
083	Major Chest Trauma W CC	1.0603
084	Major Chest Trauma W/O CC	0.6111
085	Pleural Effusion W CC	1.3240
086	Pleural Effusion W/O CC	0.8868
087	Pulmonary Edema & Respiratory Failure	1.2195
088	Chronic Obstructive Pulmonary Disease	0.9119
089	Simple Pneumonia & Pleurisy Age >17 W CC	0.9960
090	Simple Pneumonia & Pleurisy Age >17 W/O CC	0.7394
092	Interstitial Lung Disease W CC	0.9300
093	Interstitial Lung Disease W/O CC	0.7222
094	Pneumothorax W CC	1.1413

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
095	Pneumothorax W/O CC	0.6000
096	Bronchitis & Asthma Age >17 W CC	0.6430
097	Bronchitis & Asthma Age >17 W/O CC	0.5777
099	Respiratory Signs & Symptoms W CC	0.5831
100	Respiratory Signs & Symptoms W/O CC	0.5723
101	Other Respiratory System Diagnoses W CC	0.6374
102	Other Respiratory System Diagnoses W/O CC	0.5144
103	Heart Transplant	34.0923
104	Cardiac Valve Procedures W Cardiac Cath	6.0292
105	Cardiac Valve Procedures W/O Cardiac Cath	5.5656
106	Coronary Bypass W PTCA	7.1925
107	Coronary Bypass W Cardiac Cath W/O PTCA	5.2123
108	Other Cardiothoracic Proc W/O PDX Cong Anomaly	3.4442
109	Coronary Bypass W/O PTCA Or Cardiac Cath	4.0944
110	Major Cardiovascular Procedures W CC	3.1909
111	Major Cardiovascular Procedures W/O CC	2.2527
112	Percutaneous Cardiovasc Proc W/O AMI, HFI Or Shock	1.5467
113	Amputat For Circ System Disord Except Upper Limb & Toe	3.0628
114	Upper Limb & Toe Amputation For Circ System Disorders	1.5233
115	Prm Card Pacem Impl W AMI/HF/Shock or Aicd Lead Or gnrtr Proc	4.7185
116	Other Permanent Cardiac Pacemaker Implant	2.8361
117	Cardiac Pacemaker Revision Except Device Replacement	2.1148
118	Cardiac Pacemaker Device Replacement	2.0903
119	Vein Ligation & Stripping	0.8080
120	Other Circulatory System O.R. Procedures	2.2466
121	Circulatory Disorders W AMI & Major Comp, Discharged Alive	2.3300
122	Circulatory Disorders W AMI W/O Major Comp, Discharged Alive	1.2617

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
123	Circulatory Disorders W AMI, Expired	3.2313
124	Circ Disorders Except AMI, W Card Cath & Complex Diag	1.3771
125	Circ Disorders Except AMI, W Card Cath W/O Complex Diag	1.0818
126	Acute & Subacute Endocarditis	3.1835
127	Heart Failure & Shock	0.9707
128	Deep Vein Thrombophlebitis	1.0677
129	Cardiac Arrest, Unexplained	1.0190
130	Peripheral Vascular Disorders W CC	1.0381
131	Peripheral Vascular Disorders W/O CC	0.8431
132	Atherosclerosis W CC	0.8361
133	Atherosclerosis W/O CC	0.6472
134	Hypertension	0.6183
135	Cardiac Congenital & Valvular Disorders Age >17 W CC	1.4104
136	Cardiac Congenital & Valvular Disorders Age >17 W/O CC	0.7695
137	Cardiac Congenital & Valvular Disorders Age <18	1.3098
138	Cardiac Arrhythmia & Conduction Disorders W CC	0.9526
139	Cardiac Arrhythmia & Conduction Disorders W/O CC	0.5514
140	Angina Pectoris	0.7001
141	Syncope & Collapse W CC	0.8193
142	Syncope & Collapse W/O CC	0.6086
143	Chest Pain	0.5705
144	Other Circulatory System Diagnoses W CC	1.0176
145	Other Circulatory System Diagnoses W/O CC	0.5703
146	Rectal Resection W CC	2.8110
147	Rectal Resection W/O CC	1.8643
148	Major Small & Large Bowel Procedures W CC	2.9382
149	Major Small & Large Bowel Procedures W/O CC	1.7707
150	Peritoneal Adhesiolysis W CC	2.1968
151	Peritoneal Adhesiolysis W/O CC	1.0354
152	Minor Small & Large Bowel Procedures W CC	2.1639

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
153	Minor Small & Large Bowel Procedures W/O CC	0.9690
154	Stomach, Esophageal & Duodenal Procedures Age >17 W CC	2.9951
155	Stomach,esophageal & Duodenal Procedures Age >17 W/O CC	2.0702
156	Stomach, Esophageal & Duodenal Procedures Age <18	1.4695
157	Anal & Stomal Procedures W CC	1.3642
158	Anal & Stomal Procedures W/O CC	0.6035
159	Hernia Procs Except Inguinal & Femoral Age >17 W CC	1.0172
160	Hernia Procs Except Inguinal & Femoral Age >17 W/O CC	0.8174
161	Inguinal & Femoral Hernia Procedures Age >17 W CC	1.0643
162	Inguinal & Femoral Hernia Procedures Age >17 W/O CC	0.6314
163	Hernia Procedures Age <18	0.6330
164	Appendectomy W Complicated Principal Diag W CC	1.7225
165	Appendectomy W Complicated Principal Diag W/O CC	1.0711
166	Appendectomy W/O Complicated Principal Diag W CC	0.8884
167	Appendectomy W/O Complicated Principal Diag W/O CC	0.7135
168	Mouth Procedures W CC	1.2265
169	Mouth Procedures W/O CC	0.8354
170	Other Digestive System O.R. Procedures W CC	2.0783
171	Other Digestive System O.R. Procedures W/O CC	1.2233
172	Digestive Malignancy W CC	1.3410
173	Digestive Malignancy W/O CC	1.1295
174	G.I. Hemorrhage W CC	1.1336
175	G.I. Hemorrhage W/O CC	0.8787
176	Complicated Peptic Ulcer	0.8519
177	Uncomplicated Peptic Ulcer W CC	0.8292
178	Uncomplicated Peptic Ulcer W/O CC	0.5684
179	Inflammatory Bowel Disease	0.9008
180	G.I. Obstruction W CC	0.8663

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
181	G.I. Obstruction W/O CC	0.6297
182	Esophagitis,gastroent & Misc Digest Disord Age>17 W CC	0.9212
183	Esophagitis,gastroent & Misc Digest Disord Age>17 W/O CC	0.6924
185	Dental & Oral Dis Exc Extract & Restorations, Age >17	0.5204
186	Dental & Oral Dis Exc Extract & Restorations, Age <18	0.4979
187	Dental Extractions & Restorations	0.7625
188	Other Digestive System Diagnoses Age >17 W CC	0.7488
189	Other Digestive System Diagnoses Age >17 W/O CC	0.5612
191	Pancreas, Liver & Shunt Procedures W CC	4.4938
192	Pancreas, Liver & Shunt Procedures W/O CC	2.2530
193	Bil Tract Proc Exc Only Cholecyst W Or W/O CDE W CC	3.3680
194	Bil Tract Proc Exc Only Cholecystect W Or W/O CDE W/O CC	2.1308
195	Total Cholecystectomy W C.D.E. W CC	2.3683
196	Total Cholecystectomy W C.D.E. W/O CC	2.0276
197	Total Cholecystectomy W/O C.D.E. W CC	1.9304
198	Total Cholecystectomy W/O C.D.E. W/O CC	1.5425
199	Hepatobiliary Diagnostic Procedure For Malignancy	2.3890
200	Hepatobiliary Diagnostic Procedure For Non-malignancy	2.3407
201	Other Hepatobiliary Or Pancreas O.R. Procedures	3.0256
202	Cirrhosis & Alcoholic Hepatitis	0.9693
203	Malignancy Of Hepatobiliary System Or Pancreas	1.4648
204	Disorders Of Pancreas Except Malignancy	0.8555
205	Disorders Of Liver Except Malig,cirr,alc Hepa W CC	0.9435
206	Disorders Of Liver Except Malig,cirr,alc Hepa W/O CC	0.7797
207	Disorders Of The Biliary Tract W CC	1.2594

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
208	Disorders Of The Biliary Tract W/O CC	0.6050
209	Major Joint&limb Reattach Proc Of Low Ext, Exc Hip,exc Comp	2.0846
210	Hip & Femur Procedures Except Major Joint Age >17 W CC	2.0344
211	Hip & Femur Procedures Except Major Joint Age >17 W/O CC	2.0344
212	Hip & Femur Procedures Except Major Joint Age <18	1.2522
213	Amputat For Musculoskelet System & Conn Tissue Disorders	1.4896
216	Biopsies Of Musculoskeletal System & Connective Tissue	2.6531
217	Wnd Debrid & skin Grft Exc Open Wnd, for ms & Conn Tis Dis, Exc Hand	3.0053
218	Low Extrem & Humer Proc Exc Hip,foot,femur Age>17 W CC	1.9093
219	Low Extrem & Humer Proc Exc Hip,foot,femur Age>17 W/O CC	1.2956
220	Lower Extrem & Humer Proc Except Hip,foot,femur Age <18	0.9052
221	Knee Procedures W CC	1.7213
222	Knee Procedures W/O CC	0.9898
223	Maj Should/elbow Proc, Or Oth Upper Extremity Proc W CC	1.5593
224	Should,elbow Or Forearm Proc,exc Maj Joint Proc, W/O CC	0.8492
225	Foot Procedures	1.4314
226	Soft Tissue Procedures W CC	1.7577
227	Soft Tissue Procedures W/O CC	1.0753
228	Major Thumb Or Joint Proc,or Oth Hand Or Wrist Proc W CC	0.9984
229	Hand Or Wrist Proc, Except Major Joint Proc, W/O CC	0.7499
230	Local Excis & Removal Of Int Fix Devices Of Hip &	1.7811

DRG	Description	DRG WEIGHTS
	Femur	
232	Arthroscopy	0.8089
233	Other Musculoskelet Sys & Conn Tiss O.R. Proc W CC	2.7434
234	Other Musculoskelet Sys & Conn Tiss O.R. Proc W/O CC	1.5108
235	Fractures Of Femur	1.0601
236	Fractures Of Hip & Pelvis	0.9657
237	Sprains, Strains, & Dislocations Of Hip, Pelvis & Thigh	0.8497
238	Osteomyelitis	1.4275
239	Pathological Fractures & Musculoskelet & Conn Tiss Malignancy	1.5322
240	Connective Tissue Disorders W CC	1.2740
241	Connective Tissue Disorders W/O CC	0.7303
242	Septic Arthritis	0.9319
243	Medical Back Problems	0.9272
244	Bone Diseases & Specific Arthropathies W CC	0.8025
245	Bone Diseases & Specific Arthropathies W/O CC	0.5620
246	Non-specific Arthropathies	0.6331
247	Signs & Symptoms Of Musculoskeletal System & Conn Tissue	0.5222
248	Tendonitis, Myositis & Bursitis	0.6866
249	Malfunction, Reaction Or Comp Of Orthopedic Dev Or Proc	0.8072
250	Fx,sprn,strn & Disl Of Forearm,hand,foot Age>17 W CC	0.8497
251	Fx,sprn,strn & Disl Of Forearm,hand,foot Age>17 W/O CC	0.4161
252	Fx, Sprn, Strn & Disl Of Forearm, Hand, Foot Age <18	0.4382
253	Fx,sprn,strn & Disl Uparm,lowleg Ex Foot Age>17 W CC	0.8595
254	Fx,sprn,strn & Disl Uparm,lowleg Ex Foot Age>17	0.5851

DRG	Description	DRG WEIGHTS
	W/O CC	
255	Fx, Sprn, Strn & Disl Of Uparm,lowleg Ex Foot Age <18	0.5207
256	Other Musculoskeletal System & Connective Tissue Diag	0.6853
257	Total Mastectomy For Malignancy W CC	0.8564
258	Total Mastectomy For Malignancy W/O CC	0.7984
259	Subtotal Mastectomy For Malignancy W CC	0.9239
260	Subtotal Mastectomy For Malignancy W/O CC	0.7501
261	Breast Proc For Non-malig Except Biopsy & Local Excision	0.9888
262	Breast Biopsy & Local Excision For Non-malignancy	0.8243
263	Skin Graft &/or Debrid For Skn Ulcer, Cellulitis W CC	2.1984
264	Skin Graft &/or Debrid For Skn Ulcer, Cellulitis W/O CC	1.3353
265	Skin Graft &/or Debrid Exc For Skin Ulcer, Cellul W CC	2.4912
266	Skin Graft &/or Debrid Exc For Skn Ulcer, Cellul W/O CC	1.3766
267	Perianal & Pilonidal Procedures	0.5370
268	Skin, Subcutaneous Tissue & Breast Plastic Procedures	0.9150
269	Other Skin, Subcut Tiss & Breast Procedure W CC	1.2870
270	Other Skin, Subcut Tiss & Breast Procedure W/O CC	0.8575
271	Skin Ulcers	0.9387
272	Major Skin Disorders W CC	0.8414
273	Major Skin Disorders W/O CC	0.5086
274	Malignant Breast Disorders W CC	2.3640
275	Malignant Breast Disorders W/O CC	1.1423
276	Non-maligant Breast Disorders	0.5689
277	Cellulitis Age >17 W CC	0.8916
278	Cellulitis Age >17 W/O CC	0.7008
279	Cellulitis Age <18	0.4676

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
280	Trauma To The Skin, Subcut Tiss & Breast Age >17 W CC	0.6124
281	Trauma To The Skin, Subcut Tiss & Breast Age >17 W/O CC	0.4417
282	Trauma To The Skin, Subcut Tiss & Breast Age <18	0.2834
283	Minor Skin Disorders W CC	0.6276
284	Minor Skin Disorders W/O CC	0.4573
285	Amputat Of Low Limb For Endocrine,nutrit& Metabol Disord	2.3424
286	Adrenal & Pituitary Procedures	2.6281
287	Skin Gft & Wound Debrid For Endoc,nutrit & Metab Disord	1.9038
288	Gastric Procedures For Obesity	1.8395
289	Parathyroid Procedures	0.7632
290	Thyroid Procedures	0.7371
291	Thyroglossal Procedures	0.6944
292	Other Endocrine, Nutrit & Metab O.R. Proc W CC	3.8309
293	Other Endocrine, Nutrit & Metab O.R. Proc W/O CC	1.4722
294	Diabetes Age >35	0.9008
295	Diabetes Age <36	0.6764
296	Nutritional & Misc Metabolic Disorders Age >17 W CC	0.7876
297	Nutritional & Misc Metabolic Disorders Age >17 W/O CC	0.7871
298	Nutritional & Misc Metabolic Disorders Age <18	0.3656
299	Inborn Errors Of Metabolism	0.5845
300	Endocrine Disorders W CC	0.9237
301	Endocrine Disorders W/O CC	0.6695
302	Kidney Transplant	3.8473
303	Kidney, Ureter & Major Bladder Proc For Neoplasm	2.1690
304	Kidney, Ureter & Major Blad Proc For Non-neoplasm W CC	1.5144
305	Kidney, Ureter & Major Blad Proc For Non-neoplasm W/O CC	1.0775

DRG	Description	DRG WEIGHTS
306	Prostatectomy W CC	2.2061
307	Prostatectomy W/O CC	1.2270
308	Minor Bladder Procedures W CC	2.2232
309	Minor Bladder Procedures W/O CC	1.4349
310	Transurethral Procedures W CC	0.9179
311	Transurethral Procedures W/O CC	0.6970
312	Urethral Procedures, Age >17 W CC	1.4077
313	Urethral Procedures, Age >17 W/O CC	0.7106
314	Urethral Procedures, Age <18	1.0129
315	Other Kidney & Urinary Tract Procedures	2.2568
316	Renal Failure	1.2065
317	Admit For Renal Dialysis	0.3869
318	Kidney & Urinary Tract Neoplasms W CC	1.7384
319	Kidney & Urinary Tract Neoplasms W/O CC	0.7141
320	Kidney & Urinary Tract Infections Age >17 W CC	0.9014
321	Kidney & Urinary Tract Infections Age >17 W/O CC	0.6656
322	Kidney & Urinary Tract Infections Age <18	0.4835
323	Urinary Stones W CC, &/or Esw Lithotripsy	0.7778
324	Urinary Stones W/O CC	0.4667
325	Kidney & Urinary Tract Signs & Symptoms Age >17 W CC	0.9620
326	Kidney & Urinary Tract Signs & Symptoms Age >17 W/O CC	0.5335
327	Kidney & Urinary Tract Signs & Symptoms Age <18	0.4658
328	Urethral Stricture Age >17 W CC	1.0243
329	Urethral Stricture Age >17 W/O CC	0.6299
330	Urethral Stricture Age <18	0.8271
331	Other Kidney & Urinary Tract Diagnoses Age >17 W CC	1.3084
332	Other Kidney & Urinary Tract Diagnoses Age >17 W/O CC	0.6631
333	Other Kidney & Urinary Tract Diagnoses Age <18	0.8585
334	Major Male Pelvic Procedures W CC	1.5420
335	Major Male Pelvic Procedures W/O CC	1.5420

DRG	Description	DRG WEIGHTS
336	Transurethral Prostatectomy W CC	1.5327
337	Transurethral Prostatectomy W/O CC	0.6790
338	Testes Procedures, For Malignancy	0.9888
339	Testes Procedures, Non-malignancy Age >17	0.6935
340	Testes Procedures, Non-malignancy Age <18	0.6146
341	Penis Procedures	1.6573
342	Circumcision Age >17	0.6326
343	Circumcision Age <18	0.3295
344	Other Male Reproductive Sys O.R. Procs For Malignancy	1.5836
345	Other Male Reproductive Sys O.R. Procs Except For Malig	1.0892
346	Malignancy, Male Reproductive System, W CC	1.8396
347	Malignancy, Male Reproductive System, W/O CC	0.9936
348	Benign Prostatic Hypertrophy W CC	0.9761
349	Benign Prostatic Hypertrophy W/O CC	0.6583
350	Inflammation Of The Male Reproductive System	0.6482
351	Male Sterilization	0.3150
352	Other Male Reproductive System Diagnoses	0.4422
353	Pelvic Evisceration,rad Hysterectomy & Rad Vulvectomy	1.4018
354	Uterine,adnexa Proc For Non-ovarian/Adnexal Malig W CC	1.5764
355	Uterine,adnexa Proc For Non-ovarian/Adnexal Malig W/O CC	1.0415
356	Female Reproductive System Reconstructive Procedures	0.7491
357	Uterine & Adnexa Proc For Ovarian Or Adnexal Malignancy	1.9768
358	Uterine & Adnexa Proc For Ca In Situ & Nonmalig W CC	1.2104
359	Uterine & Adnexa Proc For Ca In Situ & Nonmalig W/O CC	0.7887
360	Vagina, Cervix & Vulva Procedures	0.7142

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
361	Laparoscopy & Incisional Tubal Interruption	0.7562
362	Endoscopic Tubal Interruption	0.4751
363	D&C, Conization & Radio-implant, For Malignancy	1.0020
364	D&C, Conization Except For Malignancy	0.7612
365	Other Female Reproductive System O.R. Procedures	1.4257
366	Malignancy, Female Reproductive System, W CC	1.9507
367	Malignancy, Female Reproductive System, W/O CC	0.9892
368	Infections, Female Reproductive System	0.5480
369	Menstrual & Other Female Reproductive System Disorders	0.6368
370	Cesarean Section W CC	0.9584
371	Cesarean Section W/O CC	0.8416
372	Vaginal Delivery W Complicating Diagnoses	0.6571
373	Vaginal Delivery W/O Complicating Diagnoses	0.5468
374	Vaginal Delivery W Sterilization &/or D&C	0.8190
375	Vaginal Delivery W/O.R. Proc Except Steril &/or D&C	0.6132
376	Postpartum & Post Abortion Diagnoses W/O O.R. Procedure	0.5045
377	Postpartum & Post Abortion Diagnoses W/O.R. Procedure	1.0646
378	Ectopic Pregnancy	0.7727
379	Threatened Abortion	0.5187
380	Abortion W/O D&C	0.4373
381	Abortion W D&C, Aspiration Curettage Or Hysterotomy	0.4776
382	False Labor	0.3145
392	Splenectomy Age >17	2.4662
393	Splenectomy Age <18	1.6437
394	Other O.R. Procs Of The Blood And Blood Forming Organs	1.3978
395	Red Blood Cell Disorders Age >17	0.7442
397	Other Coagulation Disorders	0.8622
398	Reticuloendothelial & Immunity Disorders W CC	1.3019

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
399	Reticuloendothelial & Immunity Disorders W/O CC	0.6136
401	Lymphoma & Non-acute Leukemia W/Other O.R. Proc W CC	2.9221
402	Lymphoma & Non-acute Leukemia W/Other O.R. Proc W/O CC	1.8017
403	Lymphoma & Non-acute Leukemia W CC	1.4177
404	Lymphoma & Non-acute Leukemia W/O CC	1.0859
406	Myelopro Disord Or Poor Diff Neopl W Maj O.R. Proc W CC	3.3865
407	Myelopro Disord Or Poor Diff Neop W Maj O.R. Proc W/O CC	0.8782
408	Myeloprolif Disord Or Poor Diff Neopl W/Other O.R. Proc	1.8385
409	Radiotherapy	1.1226
410	Chemotherapy	1.0711
413	Other Myeloprolif Dis Or Poorly Diff Neopl Diag W CC	2.4597
414	Other Myeloprolif Dis Or Poorly Diff Neopl Diag W/O CC	1.6249
415	O.R. Procedure For Infectious & Parasitic Diseases	2.5884
416	Septicemia Age >17	1.3320
417	Septicemia Age <18	0.6108
418	Postoperative & Post-traumatic Infections	0.9950
419	Fever Of Unknown Origin Age >17 W CC	0.7135
420	Fever Of Unknown Origin Age >17 W/O CC	0.5550
421	Viral Illness Age >17	0.7404
422	Viral Illness & Fever Of Unknown Origin Age <18	0.3746
423	Other Infectious & Parasitic Diseases Diagnoses	0.8433
424	O.R. Procedure W Principal Diagnoses Of Mental Illness	2.5623
425	Acute Adjustment Reaction & Psychosocial Dysfunction	0.8098
426	Depressive Neuroses	0.7229

DRG	Description	DRG WEIGHTS
427	Neuroses Except Depressive	0.8305
428	Disorders Of Personality & Impulse Control	1.0420
429	Organic Disturbances & Mental Retardation	1.2436
430	Psychoses	1.0663
431	Childhood Mental Disorders	0.9722
432	Other Mental Disorder Diagnoses	1.0511
439	Skin Grafts For Injuries	1.9455
440	Wound Debridements For Injuries Except Open Wound	2.1161
441	Hand Procedures For Injuries	0.8758
442	Other O.R. Procedures For Injuries W CC	2.2560
443	Other O.R. Procedures For Injuries W/O CC	1.0332
444	Injuries To Unspec Or Multiple Sites, Age >17 W CC	0.7143
445	Injuries To Unspec Or Multiple Sites, Age >17 W/O CC	0.4827
446	Injuries To Unspecified Or Multiple Sites, Age <18	0.4544
447	Allergic Reactions Age >17	0.4952
448	Allergic Reactions Age <18	0.3939
449	Poisoning & Toxic Effects Of Drugs Age >17 W CC	0.7643
450	Poisoning & Toxic Effects Of Drugs Age >17 W/O CC	0.7643
451	Poisoning & Toxic Effects Of Drugs Age <18	0.4901
452	Complications Of Treatment W CC	0.9207
453	Complications Of Treatment W/O CC	0.5184
454	Other Injury, Poisoning & Toxic Effect Diagnosis W CC	0.9406
455	Other Injury, Poisoning & Toxic Effect Diagnosis W/O CC	0.5334
461	O.R. Proc W Diagnoses Of Other Contact W Health Services	0.6711
462	Rehabilitation	1.4459
463	Signs & Symptoms W CC	0.8114
464	Signs & Symptoms W/O CC	0.5766
465	Aftercare W History Of Malignancy As Secondary	0.6054

DRG	Description	DRG WEIGHTS
	Diagnosis	
466	Aftercare W/O History Of Malignancy As Secondary Diagnosis	0.4308
467	Other Factors Influencing Health Status	0.6701
468	Exten O.R. Procedure Unrelated To Principal Diagnosis	4.9321
469	Principal Diagnosis Invalid As Discharge Diagnosis	0.0000
470	Ungroupable	0.0000
471	Bilateral Or Multiple Major Joint Procs Of Lower Extrem	6.7981
476	Prostatic O.R. Proc Unrelated To Principal Diagnosis	4.3823
477	Non-extensive O.R. Proc Unrelated To Principal Diagnosis	2.6374
478	Other Vascular Procedures W CC	2.0642
479	Other Vascular Procedures W/O CC	1.2054
480	Liver Transplant and/or Intestinal Transplant	10.1100
482	Tracheostomy for Face, Mouth & Neck Diagnoses	3.9199
491	Major Joint & Limb Reattachment Proc Of Upper Extremity	2.4535
493	Laparoscopic Cholecystectomy W/O CDE W CC	1.7116
494	Laparoscopic Cholecystectomy W/O CDE W/O CC	1.0959
530	Craniotomy W Major CC	6.9247
531	Nervous System Procedures Except Craniotomy W Major CC	5.7935
532	Tia, Precerbral Occlusions, Seizure & Headache W Major CC	1.3848
533	Oth Nerv Sys Disord Exc Tia, Seiz & Headache W Major CC	2.8289
534	Eye Procedures W Major CC	1.9236
535	Eye Disorders W Major CC	1.9442
536	Ent & Mouth Procs Except Major Head & Neck W Major CC	2.5763

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
538	Major Chest Procedures W Major CC	4.4477
539	Respiratory Procedures Except Major Chest W Major CC	4.4528
540	Respiratory Infections & Inflammations Exc Simple Pneumonia W Major CC	2.1162
541	Simple Pneumonia & Oth Resp Disord Exc bronchitis,asthma W Major CC	1.6661
543	Circ Disord Exc AMI,endocarditis,chf & Arrhyt W Major CC	1.6273
544	Chf & Cardiac Arrhythmia W Major CC	2.0902
545	Cardiac Valve Procedure W Major CC	11.4594
546	Coronary Bypass W Major CC	8.7119
547	Other Cardiothoracic Procedure W Major CC	12.0657
548	Oth Cardiac Pacemaker Implant/Revision Or AICD Proc W Major CC	6.7797
549	Major Cardiovascular Procedures W Major CC	6.4087
550	Other Vascular Procedures W Major CC	3.6761
551	Esophagitis,gastroent & Uncomplicated Ulcers W Major CC	1.2303
552	Digest Sys Disord Exc Esop ,gast & Uncomp Ulcers W Maj CC	1.7468
553	Digest Sys Proc Exc Hern, m Stom Or Bwl Proc W Major CC	3.6484
554	Hernia Procedures W Major CC	2.7706
555	Pancrea,liv & Oth Bil Trt Proc Exc Liv Trplnt W Major CC	5.3172
556	Cholecystectomy & Other Hepatobiliary Procs W Major CC	2.3765
557	Hepatobiliary & Pancreas Disorders W Major CC	2.2492
558	Maj Musculoskel Procs Exc Bilat Or Mult Maj Jnt W Maj CC	4.6850
559	Non-major Musculoskeletal Procedures W Major CC	3.7296
560	Musculo Disord Exc Osteo,sep Arth & Conn Tiss W Major CC	1.2230

DRG	Description	DRG WEIGHTS
561	Osteomyel,septic Arthritis & Conn Tiss Disord W Major CC	2.1390
562	Major Skin & Breast Disorders W Major CC	3.2216
563	Other Skin Disorders W Major CC	1.0980
564	Skin & Breast Procedures W Major CC	2.7628
565	Endoc, Nutrit & Metab Proc Exc Low Limb Amput W Maj CC	5.2531
566	Endoc, Nutrit & Metab Disor Exc Eat Disord Or Cf W Maj CC	1.7345
567	Kid & Urin Tract Procs Exc Kidney Transplant W Major CC	4.4894
568	Renal Failure W Major CC	2.8869
569	Kid & Urin Tract Disord Exc Renal Failure W Major CC	1.3308
570	Male Reproductive Disorders W Major CC	1.8396
571	Male Reproductive Procedures W Major CC	3.3913
572	Female Reproductive Disorders W Major CC	2.1188
573	Non-radical Female Reproductive Procedures W Major CC	3.0549
574	Blood,blood Form Organs & Immunolog Disord W Major CC	1.7149
575	Blood,blood Form Organs & Immunolog Procs W Major CC	5.8966
576	Acute Leukemia W Major CC	8.9417
577	Myeloprol Disord & Poorly Differ Neoplasms W Major CC	2.9596
578	Lymphoma & Non-acute Leukemia W Major CC	3.6695
579	Procs For Lymph,leukemia,myeloprolif Disord W Major CC	8.7256
580	Syst Infect & Parasitic Disord Exc Septicemia W Major CC	1.9618
581	Systemic Infect & Parasitic Disord Procedures W Major CC	5.1776
582	Injuries, Poisonings & Toxic Effects of Drugs	1.7100

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
	Except Multiple Trauma W Major CC	
583	Procs For Injuries Except Multiple Trauma W Major CC	3.9692
584	Septicemia W Major CC	2.4470
585	Major Stomach,esop,duod,small & Lrg Bowel Proc W Major CC	6.3726
586	Ent & Mouth Disorders, Age > 17 With Major CC	1.9914
587	Ent & Mouth Disorders, Age < 18 With Major CC	1.1098
588	Bronchitis And Asthma Age> 17 W Major CC	1.0037
589	Bronchitis And Asthma Age< 17 W Major CC	0.6935
602	Neonate, Birthwt <750g, Discharged Alive	21.9229
603	Neonate, Birthwt <750g,died	9.9688
604	Neonate, Birthwt 750-999g, Discharged Alive	16.7650
605	Neonate, Birthwt 750-999, Died	15.6277
606	Neonate, Bwt 1000-1499g, W Sig ORProc, Disch Alive	27.6407
607	Neonate, Bwt 1000-1499g, W/O Signif Or Proc, Disch Alive	7.0681
608	Neonate, Birthwt 1000-1499g, Died	9.4511
609	Neonate, Bwt 1500-1999g, W Sig ORProc, W Mult Maj Prob	14.7394
610	Neonate, Bwt 1500-1999g, W Sig ORProc, W/O Mul Maj Prob	3.3572
611	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W Mul Maj Prob Or MV 96+ Hrs	5.1749
612	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W Major Prob	3.8296
613	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W Minor Prob	3.1562
614	Neonate, Bwt 1500-1999g, W/O Sig ORProc, W/Other Prob	1.5722
615	Neonate, Bwt 2000-2499g, W Sig ORProc, W Mul Major Prob	14.1787
616	Neonate, Bwt 2000-2499g, W Sig ORProc, W/O Mul	3.2295

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
	Maj Prob	
617	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W Mul Maj Prob Or MV 96+ Hrs	2.7421
618	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W Major Prob	1.6039
619	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W Minor Prob	0.9931
620	Neonate,bwt 2000-2499g,w/o Sig ORProc, W Norm Newb Diag	0.3201
621	Neonate, Bwt 2000-2499g, W/O Sig ORProc, W/Other Prob	0.8898
622	Neonate, Bwt >2499g, W Sig ORProc, W Mult Major Prob	8.9415
623	Neonate, Bwt >2499g, W Sig ORProc, W/O Mult Major Prob	2.1306
624	Neonate, Birthwt >2499g, W Minor Abdom Proc	1.1216
626	Neonate, Bwt >2499g, W/O Sig ORProc, W Mult Major Prob Or MV 96+ Hrs	1.7723
627	Neonate, Bwt >2499g, W/O Signif Or Proc, W Major Prob	0.8778
628	Neonate, Bwt >2499g, W/O Signif Or Proc, W Minor Prob	0.3906
629	Neonate, Bwt >2499g, W/O Sign Or Proc, W Norm Newb Diag	0.2486
630	Neonate, Bwt >2499g, W/O Sig ORProc, W/Other Prob	0.4692
631	BPD And Other Chron Resp Diseas Arising In Perinatal Period	1.3731
633	Mult,other And Unspec Congenital Anomalies W CC	2.2852
634	Mult,other And Unspec Congenital Anomalies W/O CC	2.2852
635	Neonatal Aftercare For Weight Gain	1.3924
636	Infant Aftercare For Weight Gain, Age>28 Days & <1 Year	1.9727
637	Neonate, Died W/in One Day Of Birth, Born Here	0.2682
638	Neonate, Died W/in One Day Of Birth, Not Born	0.9414

DRG	Description	DRG WEIGHTS
	Here	
639	Neonate, Transferred <5 Days Of Birth, Born Here	0.2531
640	Neonate, Transferred <5 Days Of Birth, Not Born Here	0.2822
641	Neonate, Bwt >2499 Grams W ECMO	13.4550
650	High Risk Cesarean Section W CC	1.3912
651	High Risk Cesarean Section W/O CC	0.9996
652	High Risk Vaginal Delivery W Sterilization And/or D & C	1.2167
700	Tracheostomy For HIV Infection	19.0652
701	HIV W/O.R. Procedure & Ventilation Or Nutrition Support	10.4605
702	HIV W/O.R. Procedure W Multiple Major Related Infections	8.4742
703	HIV W/O.R. Procedure W Major Related Diagnosis	3.8141
704	HIV W/O.R. Procedure W/O Major Related Diagnosis	3.2017
705	HIV W Multiple Major Related Infections W TB	6.9240
706	HIV W Multiple Major Related Infections W/O TB	3.4419
707	HIV W Ventilator Or Nutritional Support	3.7718
708	HIV W Major Related Diagnosis, Discharge AMA	1.2738
709	HIV W Major Related Diag W Mult Major Or Sign Diag W TB	4.1577
710	HIV W Major Related Diag W Mult Maj OR Sign Diag W/O TB	2.0843
711	HIV W Major Relat Diag W/O Mult Maj OR Signif Diag W TB	2.7215
712	HIV W Maj Relat Diag W/O Mult Maj OR Signif Diag W/O TB	1.5821
713	HIV W Significant Related Diagnosis, Discharged AMA	0.8933
714	HIV W Significant Related Diagnosis	1.2861
715	HIV W/Other Related Diagnoses	0.6051
716	HIV W/O Other Related Diagnoses	0.5892
730	Craniotomy For Multiple Significant Trauma	7.4960

DRG	Description	DRG WEIGHTS
731	Spine, Hip, Femur Or Limb Proc For Mult Signif Trauma	6.1765
732	Other O.R. Procedures For Multiple Significant Trauma	3.6514
733	Head, Chest & Lower Limb Diagnoses Of Mult Signif Trauma	1.7576
734	Other Diagnoses Of Multiple Significant Trauma	1.7323
737	Ventricular Shunt Revision	1.9126
738	Craniotomy, Age <18 W CC	4.5824
739	Craniotomy, Age <18 W/O CC	2.4000
740	Cystic Fibrosis	2.1574
743	Opioid Abuse Or Dependence Left Against Medical Advice	0.2114
744	Opioid Abuse Or Dependence W CC	0.5347
745	Opioid Abuse Or Dependence W/O CC	0.3608
746	Cocaine Or Other Drug Abuse Or Dependence Left AMA	0.3263
747	Cocaine Or Other Drug Abuse Or Dependence W CC	0.7014
748	Cocaine Or Other Drug Abuse Or Dependence W/O CC	0.7014
749	Alcohol Abuse Or Dependence Left AMA	0.3018
750	Alcohol Abuse Or Dependence W CC	0.8665
751	Alcohol Abuse Or Dependence W/O CC	0.5300
752	Lead Poisoning	0.6685
753	Compulsive Nutrition Disorder Rehabilitation	2.4205
754	Tertiary Aftercare, Age => 1 Year	1.0005
755	Spinal Fusion W CC	3.1777
756	Spinal Fusion W/O CC	3.1777
757	Back & Neck Procedures Except Spinal Fusion W CC	1.6469
758	Back & Neck Procedures Except Spinal Fusion W/O CC	1.2315
759	Multiple Channel Cochlear Implants	8.9849
760	Hemophilia Factors Viii And Ix	1.6503
761	Traumatic Stupor & Coma, Coma >1 Hr	0.8201
762	Concussion,intracran Inj W Coma <1 Hr Or No Coma	0.4464

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
	Age <18	
763	Traumatic Stupor & Coma, Coma <1 Hr Age <18	0.9120
764	Concuss ,intracran Inj W Coma<1 Hr Or No Coma Age>17 W CC	0.8332
765	Concuss intracran Inj W Coma<1 Hr /no Coma Age>17 W/O CC	0.5454
766	Traumatic Stupor & Coma, Coma <1 Hr Age >17 W CC	1.4348
767	Traumatic Stupor & Coma, Coma <1 Hr Age >17 W/O CC	0.7802
768	Seizure & Headache Age <18 W CC	0.5792
769	Seizure & Headache Age <18 W/O CC	0.5792
770	Respiratory Infections & Inflammations Exc Simple Pneumonia Age <18 W CC	1.7841
771	Respiratory Infections & Inflammations Exc Simple Pneumonia Age <18 W/O CC	1.1278
772	Simple Pneumonia & Pleurisy Age <18 W CC	0.6024
773	Simple Pneumonia & Pleurisy Age <18 W/O CC	0.4401
774	Bronchitis & Asthma Age <18 W CC	0.6228
775	Bronchitis & Asthma Age <18 W/O CC	0.4319
776	Esophagitis,gastroent & Misc Digest Disord Age <18 W CC	0.4797
777	Esophagit,gastroent & Misc Digest Disord Age <18 W/O CC	0.3215
778	Other Digestive System Diagnoses Age <18 W CC	0.6202
779	Other Digestive System Diagnoses Age <18 W/O CC	0.4600
780	Acute Leukemia W/O Major O.R. Procedure Age <18 W CC	5.2075
781	Acute Leukemia W/O Major O.R. Procedure Age <18 W/O CC	1.8332
782	Acute Leukemia W/O Major O.R. Procedure Age >17 W CC	7.0876
783	Acute Leukemia W/O Major O.R. Procedure Age >17 W/O CC	1.8376
784	Acquired Hemolytic Anemia Or Sickle Cell Crisis	0.5964

DRG	Description	DRG WEIGHTS
	Age <18	
785	Other Red Blood Cell Disorders Age <18	0.4326
786	Major Head & Neck Procedures For Malignancy	4.1069
787	Laparoscopic Cholecystectomy W CDE	1.8547
789	Knee Revision or Major Joint & Limb Reattach Proc Low Ext, Exc Hip, For Comp	3.7541
790	Wnd Debrid & Skin Grft For Open Wound,ms Conn Tis, Exc Hnd	0.8638
791	Wound Debridements For Open Wound Injuries	1.3700
792	Craniotomy For Mult Sig Trauma W Non-traumatic Major CC	12.1776
793	Proc For Mul Sig Trauma Exc Craniot W Non-traum Major CC	6.2368
794	Diag For Multiple Signif Trauma W Non-traumatic Major CC	2.0561
795	Lung Transplant	36.1282
796	Lower Extremity Revascularization W CC	3.5366
797	Lower Extremity Revascularization W/O CC	1.5879
798	Tuberculosis With Operating Room Procedure	4.5582
799	Tuberculosis Left Against Medical Advice	2.0008
800	Tuberculosis W CC	1.2661
801	Tuberculosis W/O CC	1.2661
802	Pneumocystosis	2.3819
803	Allogeneic Bone Marrow Transplant	20.8772
804	Autologous Bone Marrow Transplant	5.4177
805	Simultaneous Kidney And Pancreas Transplant For Diabetic and Renal Failure	21.4888
806	Combined Anterior/posterior Spinal Fusion W CC	6.8196
807	Combined Anterior/posterior Spinal Fusion W/O CC	3.9928
808	Percuataneous Cardiovasc Proc W AMI, Hf Or Shock	2.3186
809	Other Cardiothoracic Procedures W PDX Congenital Anomaly	6.2120
810	Intracranial Hemorrhage	1.8148
811	Heart Assist System Implant	8.3172

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
812	Malfunction, Reaction & Comp Of Cardiac Or Vasc Dev Or Proc	0.9698
813	Nonbacterial Gastroenteritis & Abdominal Pain Age >17 W CC	0.6785
814	Nonbacterial Gastroenteritis & Abdominal Pain Age >17 W/O CC	0.6338
815	Nonbacterial Gastroenteritis & Abdominal Pain Age <18 W CC	0.3979
816	Nonbacterial Gastroenteritis & Abdominal Pain Age <18 W/O CC	0.2835
817	Hip Revision Or Hip Replacement For Complications	1.8842
818	Hip Replacements Except For Complications	2.3865
819	Create, Revise Or Remove Renal Access Device	1.5259
820	Malfunctions, Reactions & Comp Of Gu Device/Graft/Transplant	0.7523
821	Extensive Burns Or Full Thickness Burns W MV 96+ Hrs W Skin Graft	20.2280
822	Extensive Burns Or Full Thickness Burns W MV 96+ Hrs W/O Skin Graft	11.7845
823	Full Thick Burn W Skin Graft Or Inhal Inj W CC Or Sig Trauma	4.8899
824	Full Thick Burn W Skin Graft Or Inhal Inj W/O CC Or Sig Trauma	4.1930
825	Full Thick Burn W/O Skin Graft Or Inhal Inj W CC Or Sig Trauma	2.7417
826	Full Thick Burn W/O Skin Graft Or Inhal Inj W/O CC Or Sig Trauma	1.7317
827	Non-extensive Burns W Inhal Inj, CC Or Significant Trauma	1.4931
828	Non-extensive Burns W/O Inhal Inj, CC Or Sig. Trauma	1.4931
829	Pancreas Transplant For Diabetic and Renal Failure	21.4888
832	Transient Ischemia	0.7890

DRG	Description	DRG WEIGHTS
833	Intracranial Vascular Procedures W PDX Hemorrhage	4.8433
836	Spinal Procedures W CC	2.3586
837	Spinal Procedures W/O CC	2.1181
838	Extracranial Procedures W CC	1.9032
839	Extracranial Procedures W/O CC	1.0715
849	Cardiac Defib Implant W Cardiac Cath W AMI/HF/Shock	5.6694
850	Cardiac Defib Implant W Cardiac Cath W/O AMI/HF/Shock	5.6694
851	Cardiac Defibrillator W/O Cardiac Catheter	5.4784
852	Percutaneous Cardiovas Proc W Non-drug Eluting Stent W/O AMI	1.9772
853	Percutaneous Cardiovas Proc W Drug Eluting Stent W AMI	2.4087
854	Percutaneous Cardiovas Proc W Drug Eluting Stent W/O AMI	1.7132
864	Cervical Spinal Fusion W CC	2.8409
865	Cervical Spinal Fusion W/O CC	1.4101
866	Local Excision & Rem Of Int Fix Devices Exc Hip & Femur W CC	2.3017
867	Local Excision & Rem Of Int Fix Devices Exc Hip & Femur W/O CC	1.2991
874	Lymphoma & Leukemia W Major O.R. Procedure W CC	3.8098
875	Lymphoma & Leukemia W Major O.R. Procedure W/O CC	1.8455
876	Chemo W Acute Leuk As SDX Or W Use Of High Dose Chemo Agent	0.9738
877	Ecmo Or Trach W MV 96+ Hrs Or PDX Exc Face, Mouth & Neck W Maj OR	21.6449
878	Trach W MV 96+ Hrs Or PDX Exc Face, Mouth & Neck W/O Maj OR	13.4781
879	Craniotomy W Implant Of Chemo Agent Or Acute Complex CNS PDX	9.2432
880	Acute Ischemic Stroke W Use Of Thrombolytic Agent	3.6136
881	Respiratory System Diagnosis W MV 96+ Hrs	5.6576

§ 10:52-14.4 List of DRG weights

DRG	Description	DRG WEIGHTS
882	Respiratory System Diagnosis W MV < 96 Hrs	1.9020
883	Laproscopic Appendectomy	0.8467
884	Spinal Fusion Exc Cerv W Curvature Of The Spine Or Malignanc	4.3258
885	Other Antepartum Diagnoses W O.R. Procedure	0.6596
886	Other Antepartum Diagnoses W/O O.R. Procedure	0.5273

(b) In subsequent rate years, the resulting DRG weights from the recalibration process will be accessible on the New Jersey Medicaid Management Information System website *http://www.njmmis.com*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-14.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.5 Statewide base rate

(a) The Division determined a single Statewide base rate, referred to as the "Statewide base rate," for all general acute care hospitals as described in *N.J.A.C. 10:52-14.6*.

(b) The Statewide base rate is used in conjunction with increases to the Statewide base rate referred to as add-on amounts, DRG relative weights and other components defined in this subchapter, which were developed for the New Jersey DRG reimbursement system to determine the total payment for each discharge.

(c) Except for the initial rate year and in rate years in which rebasing occurs, the Statewide base rate will not change except for inflation increases as described in *N.J.A.C. 10:52-14.6(c)*.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-14.6

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§ 10:52-14.6 Determination of the Statewide base rate

(a) The Division established an initial Statewide base rate, which applies to all hospitals. Those hospitals meeting the criteria for add-on amounts in accordance with *N.J.A.C. 10:52-14.7* have rates higher than the Statewide base rate. The initial Statewide base rate is established as follows:

1. For the initial rate year, the Division used the actual payments made for claims paid during calendar year 2006. Total payments include all DRG and outlier payments. Payments for hospital-based physicians were removed since hospital-based physician groups will bill for these services separately beginning August 3, 2009. These historical 2006 payments were inflated to the rate year by applying the excluded hospital inflation factor, also referred to as the economic factor recognized under the Center for Medicare and Medicaid Services (CMS) Tax Equity and Fiscal Responsibility Act, Pub.L. 97-248 (TEFRA) target limitations, which is published annually in the Federal Register by CMS. These adjusted payments were used to establish the total budgeted amount for inpatient acute hospital services for the rate year.

2. The amount calculated in (a) above is reduced to account for the following DRG system payments: add-on amounts under *N.J.A.C. 10:52-14.7*, outlier payments, payments for alternate levels of care and the effect on payments where Medicaid/NJ FamilyCare is not the primary payer (that is, Medicare claims partially paid by Medicaid/NJ FamilyCare and third party liability claims). A reduction in payments was also made to remove an amount for utilization review services that were previously paid for by hospitals, which will become a State obligation, effective August 3, 2009.

i. If the Division does not have a contractor for hospital utilization review services by August 3, 2009, hospitals will receive separate payments equal to the aggregate amount of utilization review removed before establishing the Statewide base rate. Each hospital will receive a utilization review payment based on its proportional amount of Medicaid/NJ FamilyCare fee-for-service discharges from the most recent available 24 months of Medicaid/NJ FamilyCare paid claims data. The allocation of utilization review payments will account for closed hospitals in accordance with the method set forth in *N.J.A.C. 10:52-14.7(d)*.

(b) The Statewide base rate is increased by the hospital specific add-on amounts to determine a final rate for each hospital. The final rate for new hospitals and hospitals that had no Medicaid/NJ FamilyCare discharges in the base year are set at the Statewide base rate.

(c) The Statewide base rate will be updated annually by the excluded hospital inflation factor, also referred to as the economic factor recognized under the CMS TEFRA target limitations, which is published in the Federal Register by CMS.

(d) The initial Statewide base rate calculated in this section is $ 4,479. The Statewide base rate will not be changed, except for annual inflation as noted in (c) above, unless rebasing occurs as described in (e) below.

(e) Rebasing, which is setting the Statewide base rate using a more current year's claim payment data, will be done at the discretion of the Division with the approval of the Commissioner of DHS. Rebasing may or may not include recalibrating the DRG weights as described in *N.J.A.C. 10:52-14.3(g)*.

History

HISTORY:

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In the introductory paragraph of (a)2, and in (a)2i and (b), substituted "Medicaid/NJ FamilyCare" for "Medicaid" throughout.

Annotations

Notes

Chapter Notes

Case Notes

On the basis of *N.J.A.C. 10:52-14.6(a)*, an Administrative Law Judge (ALJ) concluded that hospitals that now were contesting the calculations, methodologies, and constitutionality of their 2013 Medicaid patient reimbursement rates may not assert a challenge in the pending proceeding based on a review of an allegedly incorrect TEFRA economic factor There was simply no cogent argument that the regulation did not re-set the base rates and re-start the clock on such determination. That finding did not, however, preclude the subsequent pass-through impact that may flow from pending judicial matters that took up review of the regulatory notice-and-comment response language in *N.J.A.C. 10:52-9.1(a)*. *AtlantiCare Reg'l Med. Ctr. et als. v. DMAHS, OAL DKT. NO. HMA 05152-2014, etc., 2015 N.J. AGEN LEXIS 184*, Initial Decision (March 30, 2015).

N.J.A.C. 10:52-14.7

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.7 Criteria to qualify for add-on amounts to the Statewide base rate

(a) Each rate year, the Division will determine if each general acute hospital participating in the New Jersey Medicaid/NJ FamilyCare program is eligible for add-on amounts. The Division determined hospital eligibility for add-on amounts in the initial rate year as described in (c) below and eligibility and add-ons will be calculated each rate year thereafter using the most recent year for which there is 24 months of Medicaid/NJ FamilyCare paid claims data. However, if the initial rate year is a partial year, add-on amounts will remain the same for the second rate-year.

(b) Each hospital will receive written notification of its final rate annually, which includes any add-on amounts for which the hospital qualifies. 2006 cost report and claim data was used to set the rates and will be used to determine add-on amounts in the initial rate year. Effective August 3, 2009, the eligibility of hospitals for add-on amounts will be determined based on the methodology in (c) below.

(c) Add-on amounts were developed to provide additional payments for high volumes of inpatient services to Medicaid/NJ FamilyCare and other low income patients. These add-on amounts increase the Statewide base rate for qualifying hospitals as a percentage add-on to the Statewide base rate. These add-on amounts are based on high volume Medicaid/NJ FamilyCare inpatient services or low income access.

1. High volume Medicaid/NJ FamilyCare inpatient services, referred to as critical services, are comprised of two categories; the first category is maternity and neonates, and the second category is mental health and substance abuse. The data used to determine eligibility as a critical service provider is patient days from the Medicaid/NJ FamilyCare fee-for-service claims for all DRGs in Major Diagnostic Categories (MDCs) 14, 15, 19, and 20, as specified in the All Patient Diagnosis Related Groups Patient Classification System Definitions Manual published by 3M Health Information Systems. The methodology determines eligibility for add-on amounts separately for each of the two categories, ranks patient day volume from high to low, and deems eligible those hospitals with patient days in the top 25 percent (referred to as the first quartile) of the total number of hospitals. Hospitals ranked in the first quartile for either category qualify for a 10 percent add-on to the Statewide base rate, and those hospitals that ranked in the first quartile of both categories qualify for a 15 percent add-on to the Statewide base rate.

2. High volume low income utilization, referred to as critical access, is expressed as a percentage and is defined as the sum of Medicaid/NJ FamilyCare fee-for-service days, Medicaid/NJ FamilyCare managed care days and charity care days, divided by total patient days. The data sources are Medicaid/NJ FamilyCare fee-for-service and charity care claims adjudicated by the New Jersey Medicaid/NJ FamilyCare fiscal agent and Medicaid/NJ FamilyCare MCO and total patient days as reported on the Medicare cost reports. Each hospital's low income utilization percentage is ranked from high to low, and hospitals in the first quartile are classified as critical access hospitals. Critical access hospitals qualify for a 10 percent add-on to the Statewide base rate. However, those hospitals with the highest low income utilization percentages for the top 10 percent of the total number of hospitals qualify for an additional five percent, which equals a 15 percent add-on to the Statewide base rate.

3. The Medicaid/NJ FamilyCare claims data used to calculate the add-on amounts as defined in (c)1 and 2 above, will be the most recent year of data available for which the Division has 24 months of Medicaid/NJ FamilyCare paid claims data as of July 1 of the year prior to the rate year. For each year the add-on amounts are calculated, the Medicaid/NJ FamilyCare claims will have DRGs assigned using the version of the AP-DRGs Grouper that was used to pay the claims in that year.

4. The total number of hospitals referenced in (c)1 and 2 above is all hospitals that are open at the beginning of the rate year. The total number of hospitals is used in the hospital counts in the calculation of add-on amounts under (c)1 above, regardless of whether or not the hospitals have data in the relevant MDCs. The number of hospitals as calculated in (c)1 and 2 above are rounded to the nearest whole number.

(d) Regarding the treatment of closed hospitals, the calculation of add-on amounts will be determined as follows:

1. Hospitals expected to be closed by December 31 of the year prior to the rate year will be excluded from the add-on calculations. Only those hospitals with a Certificate of Need for closure approved by the Department of Health (DOH) and a closure date set by DOH of December 31 or earlier will be excluded from the add-on calculations. The Division will only use hospital closure information available up to October 1 of the year prior to the rate year for add-on calculations; and

2. The add-on amounts will be calculated only once prior to the beginning of each rate year. If hospital closures occur before the December 31 prior to the rate year without prior notification as described in (d)1 above, the Division will not recalculate the add-on amounts. Hospital closures during the rate year will not result in a recalculation of the add-on amounts.

History

HISTORY:

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Made grammatical and/or technical changes regarding references to Medicaid, NJ FamilyCare, and the Department of Health throughout; in (a), substituted "rate-year" for "rate year"; in (c)1, inserted a comma following "19"; and in (c)2, substituted "MCO" for "HMO".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-14.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.8 DRG daily rates

(a) The Division will calculate DRG daily rates for each DRG for each hospital. These rates are used for calculating reimbursement in cases involving transfers, same-day discharges, and for cases in which Medicaid/NJ FamilyCare eligibility began or ended during the inpatient stay.

(b) The DRG daily rate is calculated for each DRG as follows: the hospital's final rate multiplied by the DRG weight divided by the geometric mean length of stay. The geometric mean length of stay is rounded to the nearest whole number.

History

HISTORY:

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (a), inserted a comma following "discharges", and substituted "Medicaid/NJ FamilyCare" for "Medicaid".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-14.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.9 Hospital specific Medicaid/NJ FamilyCare cost-to-charge ratios

(a) For the initial rate year and every year thereafter, the Division will calculate hospital-specific initial inpatient cost-to-charge ratios (CCR) using the most recent available submitted Medicare cost report data.

(b) The hospital-specific CCRs are calculated using total cost, total inpatient charges and total charges by cost center from the most recent available submitted Medicare cost report Worksheet C. Inpatient costs are estimated by developing the percent of inpatient charges to total charges for each cost center and multiplying that percentage times the total costs in that cost center; total inpatient costs are the sum of the inpatient costs for all cost centers. The inpatient CCR is calculated by dividing total inpatient costs by total inpatient charges.

(c) The hospital-specific CCRs are used to estimate the cost of claims for determining whether the hospital's inpatient claims exceed the cost outlier threshold in accordance with *N.J.A.C. 10:52-14.11* and also to calculate the cost outlier payments.

(d) The Division will monitor charges and payments from current claims on an ongoing basis and adjust the CCRs and payments as needed during the rate year to ensure appropriate payments. Adjustment of payments would include repricing Medicaid/NJ FamilyCare claims for the rate year.

(e) Hospitals shall notify the Division of any changes made to the hospital's charge structure. Notice shall be given 30 days prior to implementation of the change, in writing, addressed to:

Office of Reimbursement

Division of Medical Assistance and Health Services

Mail Code #44

P.O. Box 712

Trenton, NJ 08625-0712

(f) In cases in which a hospital failed to notify the Division of changes to the hospital's charge structure 30 days prior to implementation, the hospital shall pay for all costs associated with reprocessing its claims, as well as the recovery of the related overpayments and interest related to those overpayments. Reprocessing shall apply to both Medicaid/NJ FamilyCare and charity care claims. Repeated occurrences of the failure to timely notify the Division of hospital CCR changes will be forwarded to the State's Medicaid Inspector General for review and possible referral to the Office of the Attorney General's Division of Criminal Justice for legal action.

History

HISTORY:

§ 10:52-14.9 Hospital specific Medicaid/NJ FamilyCare cost-to-charge ratios

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Hospital specific Medicaid cost-to-charge ratios". In (d) and (f), substituted "Medicaid/NJ FamilyCare" for "Medicaid".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-14.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.10 Standard DRG payment calculation

The standard DRG payment is the hospital's final rate multiplied by the DRG weight.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-14.11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.11 Cost outlier payment calculation

(a) A cost outlier is defined as an inpatient stay with an estimated cost, which exceeds the greater of the State designated cost outlier threshold or the cost outlier statistical limit for a certain DRG. The cost outlier calculation is set forth in (e) below.

(b) The cost outlier statistical limit is the statistical limit for each DRG, defined as the sum of the Statewide average cost per stay for that DRG, and 1.96 times the standard deviation of the Statewide average cost per stay for that DRG.

(c) The cost outlier threshold is the fixed dollar amount cost outlier limit established by the Division, which applies to all DRGs. Applying this threshold in the cost outlier calculation assures that no cost outlier payments will be made for any DRG with a cost outlier statistical limit less than the threshold amount.

(d) The marginal cost percentage is the State-designated percentage used to determine the proportion of estimated cost that will be reimbursed as a cost outlier payment as described in (e) below. The State-designated marginal cost percentage applies to all DRGs and all hospitals.

(e) To calculate the estimated cost of a claim, the hospital's cost-to-charge ratio (CCR) is multiplied by the total covered charges on the claim. If the estimated cost amount exceeds the higher of the statistical cost outlier limit for the assigned DRG or the State-designated cost outlier threshold amount, the hospital will receive a cost outlier payment. The amount of the estimated cost in excess of the applicable cost outlier threshold or cost outlier statistical limit is multiplied by the marginal cost percentage. The resulting amount is the cost outlier payment.

(f) The cost outlier payment is made to the hospital in addition to the standard DRG payment amount.

(g) For claims with alternate level of care days, charges used to calculate cost outlier payments do not include routine per diem charges for alternate level of care days.

(h) The hospital specific CCRs used to develop the final rates were calculated using 2003 audited Medicare cost report data and 2003 claims data. Specifically, the 2003 CCRs were derived from the process used to convert charges to cost for calculating the DRG weights, as described in *N.J.A.C. 10:52-14.3*. In the initial rate year, the hospital specific CCRs used to calculate cost outlier payments were calculated using the most recent available submitted Medicare cost report data, subject to review and adjustment by the Division if necessary.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-14.12

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.12 Day outlier payment calculation for alternate level of care days

(a) The day outlier calculation only applies to claims in which there are alternate level of care days (for example, skilled nursing facility, intermediate care facility). This calculation is only used to determine qualification for payment of nursing facility days for those claims with days at an alternate level of care awaiting placement in a non-acute facility.

(b) For a total length of stay on the claim, which is higher than the day outlier limit for the assigned DRG, a day outlier payment will be made to the hospital for only those days that both exceed the day outlier limit and are classified as days awaiting placement in an alternative level of care.

(c) The day outlier payment is the number of alternate level of care days from the formula in (b) above multiplied by the annual nursing facility per diem rate set by the Facility Rate Setting program of the Division of Aging Services in the Department of Human Services.

(d) The day outlier limit is calculated for each DRG as follows: the geometric mean length of stay of the DRG plus 1.96 standard deviations of the geometric mean length of stay of the DRG, excluding any alternate level of care days. The day outlier limit is rounded to the nearest whole number.

(e) The day outlier payment is made to the hospital in addition to the standard DRG payment amount.

History

HISTORY:

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

In (c), substituted "Aging Services in the Department of Human Services" for "Senior Benefits and Utilization Management in the Department of Health and Senior Services".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-14.13

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.13 Simultaneous cost outlier and day outlier payments

If a covered hospital inpatient stay is determined to be eligible for both a cost outlier and a day outlier payment, the total reimbursement will be the sum of the standard DRG payment, the cost outlier payment and the day outlier payment.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-14.14

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.14 Payment for transfers

(a) When a patient is transferred during a covered general acute care hospital inpatient stay from one hospital to another hospital, the reimbursement to the general acute care hospitals involved in the transfer(s) will be calculated as follows:

1. The reimbursement to each transferring general hospital will be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital will be no greater than the standard DRG payment, except where the transferring hospital is eligible for an outlier payment;

2. The receiving acute care general hospital will be reimbursed the standard DRG payment. If the claim qualifies as an outlier, the receiving hospital will be eligible for outlier payments based solely on the stay at the receiving hospital; and

3. Transfer cases, both transferring and receiving, that are cost or day outliers shall be subject to the Division's utilization review to determine whether the outlier payment is medically necessary.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-14.15

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.15 Payment for same day discharges

In cases where the patient has been admitted and is discharged on the same day, reimbursement will be paid at the DRG daily rate.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:52-14.16

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.16 Payment for readmissions

(a) For New Jersey hospitals, if a patient is readmitted to the same hospital for the same or similar diagnosis within seven days, the second claim submitted for payment will be denied. For dates of service before October 1, 2015, the same or similar principal diagnosis is defined as principal diagnoses with the same first three digits in accordance with the International Classification of Diseases, 9th Edition, Clinical Modification published by Practice Management Information Corporation. For dates of service on or after October 1, 2015, the same or similar principal diagnosis is defined as principal diagnoses in the same clinical diagnosis group, determined by the range in which the first three characters of the diagnosis code fall (for example, A00 - B99 is a clinical diagnosis group entitled "Certain infectious and parasitic diseases") in accordance with the International Classification of Diseases, 10th Revision, with Clinical Modifications (ICD-10-CM). For these readmissions, requests for payment of services related to the two hospital inpatient stays shall be combined on the same claim form for reimbursement purposes.

1. In the event that one claim has a date of service prior to October 1, 2015, and another claim has a date of service on or after October 1, 2015, the principal diagnosis reported on the first claim as an International Classification of Diseases, 9th Revision, with Clinical Modifications (ICD-9-CM) diagnosis code, is compared to the principal diagnosis reported on the other claim as an International Classification of Diseases, 10th Revision, with Clinical Modifications (ICD-10-CM) diagnosis code, using the Centers for Medicare and Medicaid Services (CMS) General Equivalency Mapping (GEM) criteria, 2014 Version, which is incorporated herein by reference, as amended and supplemented. Information regarding the CMS GEM can be found at *https://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html*.

(b) The denial and subsequent combination of claims specified in (a) above may be appealed by following the process specified in (b)1 through 3 below.

1. For a hospital with non-delegated utilization review, the hospital shall request an appeal through its QIO. Hospitals that are delegated for utilization review shall request an appeal through the hospital's appeal process and obtain a final appeal decision from its Physician Advisor (PA).

2. An appeal that is approved by the QIO or PA shall be submitted to the Division's fiscal agent, along with a letter from the hospital's QIO or PA, on the QIO's or hospital's letterhead, with a determination that the two hospital stays should not be combined, including the reason supporting its determination, along with an original signature of the hospital's Physician Advisor or QIO Physician Advisor.

i. The letter from the QIO or PA shall also include the beneficiary's name, Medicaid identification number, dates of service for the paid and denied claims and the hospital's Medicaid provider number.

ii. The discharge summary shall be provided for both the paid and denied claims. For stays less than 48 hours, progress notes may be used in lieu of discharge summaries.

3. The Division's fiscal agent will forward appeals that meet the requirements in (b)1 and 2 above to the Division's Office of the Medical Director. Each admission will be evaluated by New Jersey licensed physicians on a case-by-case basis to determine whether the admission and readmission to the same hospital should be combined.

(c) The requirements in (a) and (b) above apply to New York hospitals for readmissions within 30 days and apply to Pennsylvania hospitals for readmissions within 31 days. New York and Pennsylvania appeal requests shall be mailed to:

Division of Medical Assistance and Health Services

Attention: Hospital Discharge/Readmit Appeals

Mail Code #44

P.O. Box 712

Building 7, Room 302

Trenton, NJ 08625-0712

History

HISTORY:

Amended by R.2016 d.051, effective June 6, 2016.

See: *47 N.J.R. 2041(a)*, *48 N.J.R. 962(b)*.

Rewrote (a).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:52-14.17

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL > SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

§ 10:52-14.17 Appeal of the hospital's Medicaid/NJ FamilyCare final rate

(a) For the purposes of submitting and adjudicating calculation error and rate appeals, a hospital may designate an individual or firm to represent it. This designation shall be in writing, signed by the chief executive officer of the hospital, and shall contain the representative's name, address and telephone number. This written notification shall be sent to the Division's Office of Reimbursement.

(b) Each hospital, within 15 working days of receipt of its Medicaid/NJ FamilyCare inpatient rate package, including its final rate and applicable add-on amounts, shall notify the Division of any calculation errors in its final rate. For years after the initial year that rates are set under this system, and for which no recalibration or rebasing has occurred, only calculation errors that relate to adjustments that have been made to the rates since the previously announced schedule of rates shall be permitted. For subsequent years, calculation error appeals will be limited to the mathematical accuracy or data used for recalibration, rebasing or both. Calculation errors are defined as mathematical errors in the calculations, or data not matching the actual source documents used to calculate the DRG weights and rates as specified in this subchapter. Hospitals shall not use the calculation error appeal process to revise data used to calculate the DRG weights and rates. Calculation error appeals that challenge the methodology used to calculate DRG weights and rates shall not be adjudicated as calculation error appeals, but hospitals are permitted to file such appeals as rate appeals delineated in (c) below. If upon review it is determined by the Division that the error would constitute at least a one percent change in the hospital's final rate, a revised final rate will be issued to the hospital within 10 working days. If the discrepancy meets the one percent requirement above and a revised Schedule of Rates is not issued by the Division within 10 working days, notification time frames to appeal calculation errors noted above will not become effective until the hospital receives a revised Schedule of Rates. The Division will issue a written decision regarding all calculation error appeal issues timely submitted in accordance with (d) below.

(c) Any hospital, which seeks an adjustment to its final rate shall submit a rate appeal request.

1. A hospital shall notify the Division in writing of its intent to submit a rate appeal. The notice of appeal shall be submitted to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, Mail Code #44, PO Box 712, Trenton, New Jersey 08625-0712 within 20 calendar days of receipt by the hospital of its Medicaid/NJ FamilyCare inpatient final rate, including applicable add-on amounts.

2. A hospital shall identify its rate appeal issues and submit supporting documentation in writing to the Division within 80 calendar days of receipt by the hospital of its Medicaid/NJ FamilyCare inpatient final rate, including applicable add-on amounts.

3. In order to be considered a valid rate appeal, the hospital's submission shall meet the following requirements:

i. A detailed description of the rate appeal issue shall be provided, including, but not limited to, the basis of the issue, such as whether certain portions of the Division's rate setting methodology are being challenged; and

ii. Detailed calculations showing the financial impact of the rate appeal issue on the hospital's final rate and its estimated impact on the hospital's Medicaid/NJ FamilyCare inpatient reimbursement for the rate year.

4. If the Division finds the rate appeal issue to have merit, a financial review shall be undertaken by the Division to determine whether the hospital is efficiently operated in order to qualify for a rate adjustment. The financial review shall include, but not be limited to, the following:

i. Financial ratios;

ii. Efficiency indexes;

iii. Occupancy and length of stay;

iv. Debt structure;

v. Changes in cost, revenue and services;

vi. Analysis of the hospital's audited financial statements, including all related entities; and

vii. Comparison to appropriate state and national norms.

(d) The Division shall review the documentation and determine if an adjustment is warranted.

(e) The Division shall issue a written determination with an explanation as to each calculation error appeal, or request for a rate adjustment. If a hospital is not satisfied with the Division's determination, the hospital may request an Office of Administrative Law (OAL) hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an OAL hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying, rejecting or remanding the Administrative Law Judge's initial decision. Thereafter, review may be had in the Appellate Division of New Jersey Superior Court.

History

HISTORY:

Amended by R.2018 d.104, effective May 21, 2018.

See: *49 N.J.R. 3294(a)*, *50 N.J.R. 1261(a)*.

Section was "Appeal of the hospital's Medicaid final rate". In (b), (c)1, (c)2, and (c)3ii, substituted "Medicaid/NJ FamilyCare" for "Medicaid".

Annotations

Notes

Chapter Notes

Case Notes

The standard adopted by DMAHS in *N.J.A.C. 10:52-14.17(c)*4 governing the revised proceeding for an appeal of a hospital's Medicaid final rate and that replaced the "marginal loss" standard used in N.J.A.C. 10:52-9.17 in 2009 is so vague as to be arbitrary and virtually guarantees that no party subject to its parameters will be capable of compliance with its requirements. *AtlantiCare Reg'l Med. Ctr. et als. v. DMAHS, OAL DKT. NO. HMA 05152-2014, etc., 2015 N.J. AGEN LEXIS 184*, Initial Decision (March 30, 2015).

Claims asserted on appeal by a group of hospitals that the Medicaid reimbursement for a certain year constituted an unlawful taking because the compensation received did not sufficiently cover their costs were not properly heard by an ALJ. The Office of Administrative Law did not have independent authority to hear claims and make independent decisions on issues not previously reviewed therein, nor was the OAL the proper forum for a facial constitutional challenge. *In Re Medicaid Inpatient Hosp. Reimbursement Rate Appeals for 2009-2012 v. DMAHS, OAL DKT. NO. HMA 00383-13, 2014 N.J. AGEN LEXIS 944*, Final Administrative Determination (March 7, 2014).

N.J.A.C. 10:52, Appx. A

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement a revised version will be made available at www.njmmis.com and copies will be filed with the Office of Administrative Law. The Fiscal Agent Billing Supplement may be reviewed and downloaded free of charge by accessing the following website: www.njmmis.com. For a paper copy of the Fiscal Agent Billing Supplement, write to:

UNISYS

PO Box 4801

Trenton, New Jersey 08619-4801

or contact:

Office of Administrative Law

Quakerbridge Plaza, Building 9

PO Box 049

Trenton, New Jersey 08625-0049

History

HISTORY:

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

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

Designated former Appendix as Appendix A, substituted "text" for "pages" preceding "will be distributed", inserted the sentence containing the website and inserted "paper" preceding "copy" in the last sentence of the Agency Note.

Amended by R.2011 d.010, effective January 3, 2011.

See: 42 N.J.R. 1656(a), 43 N.J.R. 43(a).

In the introductory paragraph, substituted "a revised version will be made available at www.njmmis.com" for ", replacement text will be distributed to providers", and inserted "free of charge".

Annotations

Notes

APPENDIX A

Chapter Notes

End of Document

N.J.A.C. 10:52, Appx. B

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52. HOSPITAL SERVICES MANUAL

APPENDIX B

EMC MANUAL

AGENCY NOTE: The Electronic Media Claims (EMC) Manual is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the EMC Manual a revised version will be made available at *www.njmmis.com* and copies will be filed with the Office of Administrative Law. The EMC Manual may be reviewed and downloaded free of charge by accessing the following website: *www.njmmis.com*. For a paper copy of the EMC Manual, write to:

UNISYS

PO Box 4801

Trenton, New Jersey 08619-4801

History

HISTORY:

New Rule, R.2005 d.214, effective July 5, 2005.

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

Amended by R.2011 d.010, effective January 3, 2011.

See: *42 N.J.R. 1656(a)*, *43 N.J.R. 43(a)*.

In the introductory paragraph, substituted "a revised version will be made available at *www.njmmis.com*" for ", replacement text will be distributed to providers", and inserted "free of charge".

Annotations

Notes

Chapter Notes