

(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. 10:52-4.8, 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.

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)lii.

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.

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 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 board of social services (CBOSS).

3. A hospital shall submit the form PA-1C to the county board of social services (CBOSS) immediately after the birth of a newborn of a mother who is or may become eligible for Medicaid. (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 beneficiary and her newborn shall have the same Medicaid Eligibility Identification 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 a Medicaid Eligibility Identification Number, and her newborn shall be assigned a separate Medicaid Eligibility Identification Number after being determined eligible in accordance with N.J.A.C. 10:69 or N.J.A.C. 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 CBOSS with a note of explanation (see also N.J.A.C. 10:49-2 in Administration for further information on Medicaid eligibility).

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.

10:52-1.5 Eligibility of beneficiary for hospital services

(a) Hospital services shall not be reimbursed by Medicaid or NJ FamilyCare fee-for-service programs 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 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 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, the beneficiary shall apply for retroactive eligibility, in accordance with N.J.A.C. 10:49-1.1.

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".

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 or 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 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 or 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)4, Administration.