

CHAPTER 31B

HOSPITAL FINANCING

Authority

N.J.S.A. 26:2H-1 et seq.

Source and Effective Date

R.2000 d.339, effective July 24, 2000. See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Executive Order No. 66(1978) Expiration Date

Chapter 31B, Hospital Financing, expires on July 24, 2005.

Chapter Historical Note

Subchapter 1, Hospital Rate Commission, was adopted as R.1979 d.285, effective July 20, 1979. See: 11 N.J.R. 233(a), 11 N.J.R. 439(c). Pursuant to Executive Order No. 66(1978), Subchapter 1 expired on July 19, 1984.

Subchapter 4, Financial Elements and Reporting, was adopted as R.1979 d.407, effective October 17, 1979. See: 11 N.J.R. 329(a), 11 N.J.R. 550(a).

Subchapter 3, Financial Monitoring and Reporting Regulations, was adopted as R.1979 d.408, effective October 17, 1979. See: 11 N.J.R. 436(a), 11 N.J.R. 550(b).

Subchapter 2, Hospital Reporting of Uniform Bill—Patient Summaries (Inpatient), was adopted as R.1979 d.450, effective November 13, 1979. See: 11 N.J.R. 435(b), 11 N.J.R. 621(a).

Subchapter 5, Diagnosis Related Groups, was adopted as R.1982 d.27, effective February 1, 1982. See: 13 N.J.R. 726(b), 14 N.J.R. 147(b).

Subchapter 6, Mobile Intensive Care Units, was adopted as R.1982 d.38, effective February 16, 1982. See: 13 N.J.R. 647(a), 14 N.J.R. 208(a).

The Executive Order No. 66(1978) expiration date for Subchapter 2, Hospital Reporting of Uniform Bill—Patient Summaries (Inpatient), was extended by gubernatorial directive from November 14, 1984 to February 12, 1985 and the Executive Order No. 66(1978) expiration dates for Subchapter 3, Financial Monitoring and Reporting Regulations, and Subchapter 4, Financial Elements and Reporting, were extended by gubernatorial directive from October 17, 1984 to October 17, 1985. See: 16 N.J.R. 2733(a).

Pursuant to Executive Order No. 66(1978), Subchapter 2, Hospital Reporting of Uniform Bill—Patient Summaries (Inpatient), was readopted as R.1984 d.610, effective December 17, 1984. See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

Pursuant to Executive Order 66(1978), Subchapter 3, Financial Monitoring and Reporting Regulations, was readopted as R.1985 d.551, effective October 15, 1985. See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Pursuant to Executive Order No. 66(1978), Subchapter 4, Financial Elements and Reporting, was readopted as R.1985 d.550, effective October 15, 1985. See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Subchapter 7, Uncompensated Care Trust Fund, was adopted as R.1987 d.298, effective July 20, 1987. See: 19 N.J.R. 495(a), 19 N.J.R. 1297(a).

Subchapter 6, Mobile Intensive Care Units, was repealed by R.1990 d.462, effective September 17, 1990. See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Subchapter 5, Diagnosis Related Groups, was repealed by R.1993 d. 593, effective November 15, 1993. See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Subchapter 7, Uncompensated Care Trust Fund, was repealed by R.1993 d. 668, effective December 20, 1993. See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

Pursuant to Executive Order No. 66(1978), Chapter 31B, Hospital Rate Setting, was readopted as R.1990 d.462, effective August 17, 1990. See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Petition for Rulemaking. See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a).

Pursuant to Executive Order No. 66(1978), Chapter 31B, Hospital Financing, was readopted as R.1995 d.507, effective August 14, 1995. See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Subchapter 5, Standards for Hospital Notification Regarding Offset of Medicaid Payments and Charity Care Subsidy Payments to Collect Hospital Debts Due to the State, was adopted as new rules by R.1998 d.569, effective December 7, 1998. See: 30 N.J.R. 3179(a), 30 N.J.R. 4221(a).

Pursuant to Executive Order No. 66(1978), Chapter 31B, Hospital Financing, was readopted as R.2000 d.339, effective July 24, 2000. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:31B-1.1 Purpose and scope

The purpose of this chapter is to satisfy the requirements of the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187; and P.L. 1992, c.160, and support the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost, be available to inhabitants of the State.

Amended by R.1993 d.593, effective November 5, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Case Notes

New Jersey statutes and regulations were not preempted by ERISA because they referred to self-funded union plan. *United Wire, Metal and Mach. Health and Welfare Fund v. Morristown Memorial Hosp.*, C.A.3 (N.J.)1993, 995 F.2d 1179, certiorari denied 114 S.Ct. 382, 126 L.Ed.2d 332, leave to file for rehearing denied 115 S.Ct. 536, 130 L.Ed.2d 438, rehearing denied 114 S.Ct. 651, 126 L.Ed.2d 608, certiorari denied 114 S.Ct. 383, 126 L.Ed.2d 332, rehearing denied 114 S.Ct. 743, 126 L.Ed.2d 706.

Rate setting and review; peer comparison; reimbursement. In re: 1976 Hospital Reimbursement for Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656 (1979).

8:31B-1.2 Definitions

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

“Adjusted admissions” means inpatient admissions increased to reflect outpatient activity and is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

“Base year” means the year from which historical cost data are utilized.

“Current Cost Base” means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period.

“Department” means the New Jersey Department of Health and Senior Services.

“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.

“Financial Elements” means those items of revenue, expenses and other data defined in N.J.A.C. 8:31B-4 for reporting to the Department of Health and Senior Services.

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

“Neonate” means a newborn less than 29 days of age.

“Preliminary Cost Base” 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.

“Reporting Year” means the year in which current financial and statistical data is being reported.

“Uniform Bill-Patient Summary” (also referred to as the UB-82) means a common billing and reporting form used by the hospital for each inpatient (see N.J.A.C. 8:31B-2).

“Utilization Review Committee” means a group of physicians in a designated hospital who review the health care provided to patients.

“Utilization Review Organization (URO)” means a group of physicians within a designated geographical area who review the health care provided to patients in area hospitals.

Amended by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Definitions for full rate review and prospective operating adjustment added.

Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Definition for Preliminary Cost Base revised.
 Amended by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.
 See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Inserted “Department”.

SUBCHAPTER 2. HOSPITAL REPORTING OF UNIFORM BILL DATA (INPATIENT AND SAME-DAY SURGERY OUTPATIENT)

8:31B-2.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a single patient data reporting system to satisfy the

health planning requirements of the Health Care Reform Act of 1992 (P.L.1992, c.160). The subchapter incorporates herein by reference the National Uniform Bill (UB-92 HCFA-1450) as the common hospital billing format for all payers. The data elements and design of the form have been determined by the National Uniform Billing Committee (NUBC). The NUBC includes representatives of the Federal Government, major payers and hospital associations.

(b) This subchapter will continue to allow hospitals to:

1. Satisfy Department of Health and Senior Services reporting requirements for patient level clinical and financial information;
2. Allow for common and consistent reporting of revenues for services related to patient care; and
3. Promote uniformity and accuracy of patient data reporting. Confidentiality of individual patients and physicians shall be maintained in fulfilling the above purposes.

Amended by R.1984 d.610, effective January 7, 1985.
See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
Amended by R.1994 d.488, effective September 19, 1994.
See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-2.2 Implementation

Beginning January 1, 1981, N.J.A.C. 8:31B-2.1, the rule on Hospital reporting of Uniform Bill Patient Summaries (Inpatient), has been used as a common billing and reporting mechanism for each inpatient discharged and ambulatory same day surgery outpatient treated in each acute care general hospital.

Amended by R.1981 d.404, effective November 2, 1981.
(to become operative January 1, 1982).
See: 13 N.J.R. 410(a), 13 N.J.R. 756(c).
Added paragraph (g) 1-3.
Amended by R.1984 d.610, effective January 7, 1985.
See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
Amended by R.1989 d.154, effective March 20, 1989.
See: 20 N.J.R. 3057(a), 21 N.J.R. 752(b).
Newborn inpatient birthweight and Severity of Illness indicators added to DRGs.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
(c)2i revised.
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
Substituted a reference to acute care general hospitals for a reference to hospitals covered under Chapter 83, P.L. 1978.

8:31B-2.3 Billing form

(a) The UB-92 is a multi-part form set. Detailed specifications are included with the UB-92 completion guidelines.

(b) The form is designed to be typed or computer printed. It will be available as unit sets or in a printed version. The number of copies in each form set will be determined by the hospital according to its planned use of the forms.

Amended by R.1984 d.610, effective January 7, 1985.
See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
Amended by R.1994 d.488, effective September 19, 1994.
See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
In (a), deleted "printed in red ink" at the end.

8:31B-2.4 Guidelines for completion of the patient billing and abstract form

(a) Procedural guidelines for completing the patient billing and abstract form follows:

1. Guidelines for completing the billing form, UB-92 HCFA-1450, have been developed by the NUBC for Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Commercial Insurers.

2. Specific instructions for Blue Cross, Medicaid, and other payers will be provided by those payers.

3. Additional data elements required for the Department of Health and Senior Services by this rule are described in detail by an addendum to the National Uniform Bill Manual. Note: The addendum consists of instructions for filling out the new, Federally mandated form; copies of the addendum can be obtained from the Department.

(b) Billing timelines requirements are as follows:

1. A UB-92 must be completed, finalized and submitted to the Data Intermediary for each patient within 30 days of discharge of the patient.

2. Where claims administration and cash flow considerations would dictate a more current billing than the 30 day requirement, a preliminary version of the UB-92 containing only those items required for the particular payer need be utilized at the time of billing. In interim billing cases, it is required that the full patient billing and abstract information be completed and submitted to the data intermediary in compliance with the data intermediary time limits and these rules, specifically N.J.A.C. 8:31B-2.5(g). Data items reported to the data intermediary for transmission to the Department of Health and Senior Services shall not differ from data upon which payment was based.

3. Notwithstanding (b)1 and 2 above, at such time as electronic data submission shall be formally adopted as a hospital's means of discharge data transmission, which adoption shall occur no sooner than 30 days after written notice by the Department to the hospital and the data intermediary, the hospital shall thenceforth submit discharge data daily to the data intermediary. That daily submission shall include the data on all discharges billed the previous day.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Hospital Rate Setting Commission required to retroactively correct Health Department error affecting equalization factor. *Alexian Bros. Hosp. v. State, Dept. of Health, Hosp. Rate Setting Com'n*, 242 N.J.Super. 411, 577 A.2d 164 (A.D.1989).

Hospital had statutory right to appeal rate reimbursement issues under Health Care Facilities Act. In re Amendment of N.J.A.C. 8:31B-3.31 and N.J.A.C. 8:31B-3.51, 119 N.J. 531, 575 A.2d 481 (1990).

Health Department acted within authority to establish hospital rate setting system. In re Amendment of N.J.A.C. 8:31B-3.31 and N.J.A.C. 8:31B-3.51, 119 N.J. 531, 575 A.2d 481 (1990).

In determining how to allocate reduction in Medicare payment, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Regulations establish criteria against which Hospital Rate Setting Commission can evaluate arguments; reconciliation process not rule-making by Commission; order modification proper. In re 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.2 (Reserved)

8:31B-3.3 Uniform reporting: current costs and other financial data

(a) The Commissioner shall collect and review the actual costs for the institutions as reported in accordance with the Financial Elements and Reporting rules (N.J.A.C. 8:31B-4). Costs so reported shall be subject to revision due to subsequent audits in accordance with N.J.A.C. 8:31B-3.17.

(b) In addition to (a) above, hospitals shall submit, on a quarterly basis, unaudited financial data to the Department. The data shall be submitted within 60 days from the end of each calendar quarter. The annual cost report forms for the balance sheet and statement of operation (the L-1 and L-3 forms from the New Jersey Acute Care Hospital Cost Report) shall be used for the quarterly submissions. The information shall agree with the hospital's internal unaudited financial statements. Except as otherwise provided in these rules, the information shall be consistent with Generally Accepted Accounting Principals (GAAP).

(c) Late submission of current cost and financial data, as defined in (b) above and N.J.A.C. 8:31B-4.6(c), including Audited Financial Statements, will result in a penalty for each working day past the appropriate submission date. A fine of \$100.00 per working day will be assessed by the Department for late submission of the Acute Care Hospital Cost Reports. A fine of \$50.00 per working day will be assessed by the Department for late submission of quarterly

financial data specified in (b) above. All of the specified forms, containing the required information, are necessary for a submission to be considered complete. A separate fine of \$100.00 per working day will be assessed for late submission of the Acute Care Hospital final audited Financial Statements.

Amended by R.1983 d.597, effective December 19, 1983.
See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a): Cross-reference changed from N.J.A.C. 8:31A-5.5 to N.J.A.C. 8:31B-4. (b) added.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): added "including Audited Financial Statements,".

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Penalty mandatory; to be reflected in next year's rates.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Rewrote (b) and (c).

Case Notes

New Jersey statutes and regulations were not preempted by ERISA because they referred to self-funded union plan. *United Wire, Metal and Mach. Health and Welfare Fund v. Morristown Memorial Hosp.*, C.A.3 (N.J.)1993, 995 F.2d 1179, certiorari denied 114 S.Ct. 382, 126 L.Ed.2d 332, leave to file for rehearing denied 115 S.Ct. 536, 130 L.Ed.2d 438, rehearing denied 114 S.Ct. 651, 126 L.Ed.2d 608, certiorari denied 114 S.Ct. 383, 126 L.Ed.2d 332, rehearing denied 114 S.Ct. 743, 126 L.Ed.2d 706.

Exception to Administrative Procedure Act's procedural requirements did not apply to Hospital Rate Setting Commission's rate adjustment cap. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

Hospital Rate Setting Commission's cap on settlement of hospital rate appeals was rule-making. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

1976 Rate Review guidelines. In re: 1976 Hospital Reimbursement for Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656 (1979).

Objectives of 1979 rate review program to require hospitals to establish reasonableness of current costs incurred and increases; burden of reasonableness proof on hospital; measure is additional cost against dollar value or benefit derived; policy fringe benefits, fiscal and plant budget requests disallowed (citing former N.J.A.C. 8:31-17). In re: *Elmer Hospital*, 4 N.J.A.R. 76 (1979).

8:31B-3.4 through 8:31B-3.10 (Reserved)

8:31B-3.11 Same day surgery

(a) Same Day Surgery is considered an alternative mode of health care delivery which the Department of Health and Senior Services considers to be efficient and worthy of encouragement. Same Day Surgery is intended to lower the cost of health care and provide the appropriate level of care to patients who are otherwise classified as inpatients. The patient, by definition:

1. Is identified on the Uniform Bill-Patient Summary (UB-PS) as a 131 or 136 bill type in accordance with

N.J.A.C. 8:31B-2.1 and discharged before midnight of the day of admission, so admission date and discharge date are the same;

2. 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 UB-PS;

3. Had a normal discharge, for example, was not transferred, did not leave AMA, and was not discharged dead.

Amended by R.1982, d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a), 15 N.J.R. 43(a).

Text changed from "Same day surgical units" to provide for "Same day surgery".

Amended by R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a) amended; (a) 1, 2 and 3 added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Reference to 2.1 added.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991.)

See: 23 N.J.R. 227(a).

Provision for petition for adjustment deleted at (b).

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted without change.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Reporting date in (b) changed to April 30.

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.12 through 8:31B-3.15 (Reserved)

8:31B-3.16 Current Cost Base

(a) A hospital's Current Cost Basis is defined as the actual costs and revenue as identified in the Financial Elements in the base reporting period as recognized by the New Jersey Department of Health and Senior Services.

(b) The Current Cost Base is also used as the basis for the health care (hospital) analysis and reporting system.

(c) Hospitals' actual cost reports cannot be substituted or rearranged once the Department has determined that the actual cost submission is suitable for entry into the data base. The Department shall provide 30 days' notice of its intent to close the data base.

Amended by R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added (d).

Amended by R.1989 d.383, effective July 17, 1989.

See: 21 N.J.R. 661(b), 21 N.J.R. 2087(a).

Added (e).

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Subsection (a) clarified. Base-year cost data base expanded in (b)4, 5 and 6, to include approved reimbursement for waste disposal costs; calculation of economic factor; and calculation of the technology factor. Cost base for 1990 rate year clarified at (b)7.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Deletion of (b)4 and (e), on 1986 cost base adjustments.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Notice to hospitals of data base closing required; no adjustments after closing.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Case Notes

Hospital's preliminary cost basis accommodates competing policies underlying Health Care Facilities Planning Act. *Slocum v. Hospital Rate Setting Com'n*, N.J. Dept. of Health, 240 N.J.Super. 566, 573 A.2d 971 (A.D.1990).

In determining how to allocate reduction in Medicare payment, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Treating final reconciliation adjustments as automatic did not violate Hospital Rate Setting Commission's duty to ensure that adjustments to scheduled rates are necessary and appropriate. In the *Matter of 1983 Final Reconciliation Adjustments of Greenville Hospital*, 214 N.J.Super. 607, 520 A.2d 809 (App.Div.1987).

Hospital Rate Setting Commission erred in refusing to allow hospital to recalculate number of full-time equivalent residents and residents' salaries based on accepted standard. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Commission*, 214 N.J.Super. 599, 520 A.2d 805 (App.Div.1987).

Current cost base is a key component in the derivation of the preliminary cost base and the certified revenue base; current cost base reflects hospital's actual experiences in a given Diagnosis Related Group for the base year; rate setting procedure review; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for *Jersey Shore Medical Center*, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

Commission's denial of inclusion of employee pension and dental plans in reimbursement rate calculation not supported by record; remand to Commission for proper determination. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

Regulations explain criteria to determine reasonableness of proposed hospital budgets; 1979 minimum base period challenge disallowed; uncompensated services not reimbursable cost but deduction from revenue; other general services; calculation using economic factor formula (citing former N.J.A.C. 8:31-17). In re: *Millville Hospital*, 6 N.J.A.R. 456 (1980).

8:31B-3.17 Financial elements reporting/audit adjustments

(a) The aggregate Current Cost Base is developed from financial elements reported to New Jersey State Department of Health and Senior Services and includes:

1. Costs related to patient care (as defined in N.J.A.C. 8:31B-4.32);

2. Less net income from specified sources (as defined in N.J.A.C. 8:31B-3.25); and

3. Capital Facilities Costs: Capital cash requirements (as defined in N.J.A.C. 8:31B-4.21).

(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 Department of Health and Senior Services may perform a cursory or detailed on-site review at the Department'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 Current Cost Base (CCB). Any adjustments made subsequent to the financial review (including Medicare and Medicaid audits and New Jersey State Department of Health and Senior Services reviews) shall be brought to the attention of the Commissioner by the hospital, the Department of Health and Senior Services, appropriate fiscal intermediary or payer where appropriate and shall be applied proportionately to the Cost Base.

(c) Hospitals shall submit a complete list of exceptions to the proposed audit adjustments, together with appropriate written documentation, within 60 days of receipt of the Department's written summary of these adjustments, or these adjustments shall be implemented in accordance with (b) above. Consideration shall be given only to documentation submitted in accordance with this schedule.

Amended by R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Amended (b) to permit cursory or detailed review.

Amended by R.1984 d.531, eff. November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): Added "net"; deleted "for each individual discrepancy".

Amended by R.1988 d.24, effective January 4, 1988.

See: 19 N.J.R. 1145(a), 20 N.J.R. 74(a).

Deleted text in (a)3 "plus a formula allowance".

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

References to 3.25 and 3.40 added; audit adjustment provisions added at (c) and (d).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

Case Notes

Hospital Rate Setting Commission required to retroactively correct Health Department error affecting equalization factor. *Alexian Bros. Hosp. v. State, Dept. of Health, Hosp. Rate Setting Com'n*, 242 N.J.Super. 411, 577 A.2d 164 (A.D.1989).

8:31B-3.18 through 8:31B-3.23 (Reserved)

8:31B-3.24 Off-site primary care

The Commissioner may establish demonstration projects involving hospital-affiliated off-site outpatient facilities providing primary care under an agreement with the Department of Health and Senior Services. For hospitals selected

to participate in such programs, there may be reporting requirements, as defined in rules by the Department of Health and Senior Services, to evaluate these programs.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text on reasonable indirect patient care costs transferred to 3.23; text on off-site primary care added as new rule.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.25 Net income from other sources

(a) The new gain (loss) from Other Operating and Non Operating Revenues (as defined in N.J.A.C. 8:31B-4.61 through 4.67), and expenses of the reporting period are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 8:31B-4.61 through 4.67) as reported to the New Jersey State Department of Health and Senior Services.

(b) Such revenue shall include all Other Operating and Non-Operating Revenues and Expenses reported per SHARE cost center costs and "expense recoveries" as Case B (see N.J.A.C. 8:31B-4.61 through 4.67), and all other items reported per the Uniform Cost Reporting Regulation as to their Case specified in N.J.A.C. 8:31B-4.61 through 4.67.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Certified revenue base added.

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.26 Update factors

(a) Economic Factor: An economic factor shall be calculated for each hospital. It shall take into account the level of hospital expenses and replacement cost of major moveable equipment, using the cost components reported to the New Jersey State Department of Health and Senior Services. The economic factor is the measure of the change in the prices of goods and services used by New Jersey hospitals. The economic factor shall be based, as far as possible, on recorded price changes. For that part of the period covered by the economic factor for which recorded prices are unavailable, the economic factor shall be based on the best available forecast of price trends.

1. The economic factor shall be determined by the Commissioner of Health and Senior Services prior to the beginning of each year.

2. The economic factor calculation shall include the most current measure of inflation/deflation and will reflect changes in a fixed market basket of goods as determined by the Commissioner. The economic factor should not take into account changes in technology or disease

entities as these are adjusted through the technology factor.

(b) **Cost Change Factor:** An actual cost change factor shall be calculated for each hospital, in accordance with N.J.A.C. 8:31B-4. It shall take into account the level of hospital expenses and replacement costs of major moveable equipment, using the cost components reported to the New Jersey State Department of Health and Senior Services. The actual cost change factor is the actual measure of the change in the prices of goods and services used by New Jersey hospitals, to be based upon reported expenses.

(c) **Technology Factor:** 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 Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost increasing technologies. Allowances for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC will be included, if available.

Amended by R.1983 d.206, effective June 6, 1983.

See: 15 N.J.R. 471(a), 15 N.J.R. 920(a).

In (a), changed how economic factor is calculated. Deleted old (b)1-2 and added new (b). Added (c).

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

Reference to Appendix II (cost components) added.

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Labor 1 costs capped at 6%. For 1989, labor proxy changed to blend of Bureau of Labor Statistics Index and regional data.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Text on labor proxy, specific years and (a)3 deleted; reference to 3.72(a)1 added; (a)iii adjusted.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

"Accept" deleted; "implement" added; (c) through (i) (Prospective opening adjustment) added.

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Basis of economic factor deleted, new basis added at (a)5, (e), (i)-(1) added; reference to 1992 added to (f) and (g).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-3.27 through 8:31B-3.42 (Reserved)

8:31B-3.43 Adjustment of charges

A hospital shall submit to the Commissioner upon request a copy of its charges in use during the current year for review and monitoring purposes.

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added plus or minus variances of 20 percent in the third 12 months.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Substantially amended.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): "15" was "20".

Amended by R.1989 d.79, effective February 6, 1989.

See: 20 N.J.R. 2542(a), 21 N.J.R. 296(a).

Substituted "30" for "45" and "fifteen" for "thirty".

Correction: Text, "subsidization and how . . . Schedule of Rates." in (d) was inadvertently dropped from the 3-20-89 Update.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Working days changed to calendar days.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-3.44 through 8:31B-3.65 (Reserved)

8:31B-3.66 Health planning fees

(a) A charge of \$5.00 per adjusted admission, as defined by the American Hospital Association, for each adjusted admission in the most recent complete year shall be assessed each acute care hospital.

(b) An adjusted admission, as defined by the American Hospital Association, means admissions multiplied by total gross revenue divided by inpatient gross revenue.

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Fee increased from \$.50 to \$1.00.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

\$2.00 fee was \$1.00.

Amended by R.1989 d.472, effective September 5, 1989.

See: 21 N.J.R. 1606(a), 21 N.J.R. 2787(a).

Fee changed from \$2.00 to \$5.00.

Amended by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B-3.67 through 8:31B-3.69 (Reserved)

8:31B-3.70 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.

See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

Section was "Revenue Cap".

8:31B-3.71 through 8:31B-3.75 (Reserved)

8:31B-3.76 Necessity and appropriateness of health care services

(a) P.L.1978, c.83 provides that reasonable payment may be made only for "appropriate and necessary health care services of high quality required by (each) hospital's mix of patients." In order to discharge this statutory obligation, two systems are required: The reimbursement system, payment by the case, establishes reasonable rates for patients who are correctly assigned to a Diagnosis Related Group (DRG). A utilization review organization system is required to ensure that the hospital services which are provided are appropriate, necessary, and of high quality.

1. Denial of Payment: Unnecessary admissions: The qualifying utilization review organization shall direct the appropriate payor to deny payment concerning any admission for which medical necessity has not been certified; provided, however, that a payor may agree with any hospital to reimburse charges for a grace period, not to exceed three calendar days, after notification to the patient, hospital, physician, and payor, of denial of payment certification.

2. Adjustment of Payment shall be made as follows:

i. Continuing necessity: The qualifying utilization review organization shall prospectively direct the appropriate payor to deny charges for such items, services or days for which continuing medical necessity has not been certified; provided, however, that a payor may agree to reimburse any hospital for a grace period, not to exceed three calendar days, after notification of the patient, physician, payor and hospital of the denial of medical necessity for continuing stay.

ii. The following shall apply to a finding of an inappropriate level of care: Should the qualifying utilization review organization determine that, for a portion of the patient's length of stay, the level of care is appropriate to a skilled nursing facility and/or intermediate care facility level-of-care, and that a hospital has documented a good faith continuing effort to obtain placement of the patient to the appropriate level-of-care, a Skilled Nursing Facility (SNF) and/or Intermediate Care Facility (ICF) rate, calculated as follows, will become the basis for determination of reasonable Direct Patient Care Costs for that portion of the stay in an atypical case.

(1) Reimbursement for each eligible patient will be based upon a Statewide weighted average SNF or ICF per diem rate of Medicaid participating long-term care facilities, in effect as of January 1 of the rate year. Separate Statewide weighted average per diem rates will be calculated for both the Skilled (SNF) and Intermediate (ICF) levels of care patients as follows:

(2) Multiply the SNF payment rate, of each Medicaid long-term care facility, in effect as of January 1 of the rate year by the total Medicaid SNF patient days as reported on the most recent Medicaid cost report (12-month period). The Statewide Medicaid total SNF dollars are divided by the total Statewide Medicaid SNF days to arrive at a weighted average SNF per diem. The ICF per diem is calculated following the same steps using total Medicaid ICF days and costs. These SNF and ICF rates will be final for billing purposes and final reconciliation.

iii. The following shall apply to a finding of misassigned DRGs: The qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to make an appropriate adjustment to the

price per case where the DRG to which the patient is correctly assigned differs from the DRG on which payment was based. Similarly, the qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to classify cases as outpatients, to be billed as outpatients when there is a finding of medical necessity for items and services rendered, but no medical necessity for inpatient admission.

3. The following shall apply to apportionment of liability: Upon a prospective finding that certain days, services, or items will not be necessary, the qualifying review organization shall so advise the respective patient, attending physician, hospital, and payer. Once all involved parties have had due notice and have exhausted all appeals, under N.J.A.C. 8:31B-3.78(a)1vii, the utilization review organization may direct the hospital to assign financial liability for such unnecessary days, services, or items to the patient. Accordingly, except for any grace days which a payer may agree to reimburse pursuant to this section (N.J.A.C. 8:31B-3.79), liability for the appropriate price per case shall be fixed at the point in time at which the patient was eligible for discharge; and any further days or services shall, subject to prevailing contracts and statutes, be the sole liability of the patient to be reimbursed to the hospital at a rate, determined by the hospital, no greater than its charges for such days or services established in accordance with N.J.A.C. 8:31B-3.53 through 3.57. Revenues received by the hospital in accordance with this provision shall be treated as Expense Recoveries in accordance with N.J.A.C. 8:31B-4.62 through 4.67.

4. Reporting shall be accomplished as follows: The qualifying utilization review organization shall report all denials and adjustments to the hospital, the appropriate physician, and the payer in a timely manner. All denials and adjustments shall be compiled by diagnosis related group and by hospital, and reported to both the Commission and the Department on, at least, an annual basis. However, except for adjustments made in accordance with N.J.A.C. 8:31B-3.71 through 3.86, any adjustment in a hospital's budget, or in a standard for a Diagnosis Related Group or set of Diagnosis Related Groups shall be made only by the Commission, upon recommendation by the Commissioner through a change in the rate period or schedule of Rates, approved by the Health Care Administration Board (see N.J.A.C. 8:31B-3.87).

As amended, R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added per diem rate "in effect as of January 1 and July 1 of each year".

As amended, R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(b)2ii(2): last sentence added.

Amended by R.1985 d.359, effective July 15, 1985.

See: 17 N.J.R. 873(a), 17 N.J.R. 1761(a).

(b)2ii(2) deleted and new text added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

References to typical and atypical cases deleted; provisions added for misassigned DRGs and apportionment of liability.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.80 Qualification procedure

(a) Submission of plans:

1. Any payor, Professional Standards Review Organization, or other qualified entity may submit to the Commissioner, a plan reasonably designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78.

2. A plan may be designed to cover all patients to be admitted by a hospital or group of hospitals, or an appropriate portion thereof, and, where appropriate, on a hospital specific basis, may provide for a form of delegated review in which the hospital performs certain review functions, with monitoring and oversight by the qualifying utilization review organization. Each plan shall be designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78 in the most efficient manner and shall include a payment proposal.

i. Each plan shall contain a review protocol, a description of how review criteria are to be determined and employed, and a plan for focusing reviews;

ii. Each plan which includes provision for delegated reviews shall include a description of how the performance of review at delegated hospitals will be monitored, and of the procedures for awarding and suspending delegation;

iii. The payment proposal shall, at a minimum, itemize proposed cost by category of direct review costs, overhead costs, monitoring costs, physician compensation, and other.

(b) Department review and recommendation:

1. The Department shall review all such plans within 90 days of submission and certify those plans which, consistent with L. 78, c.83:

i. Can be reasonably expected to fully meet the criteria set forth in N.J.A.C. 8:31B-3.78;

ii. Are designed to provide the services required above in the most efficient manner; and

iii. Consistent with high quality medical care, can be expected to best promote effectiveness and efficiency with respect to the health care delivery system, taken as a whole.

2. Special consideration shall be given to organizations which submit joint plans providing for coverage of wide geographical areas. In order to promote effectiveness and efficiency with respect to the health care system, the Department shall seek to avoid the undue proliferation of plans. Where appropriate, the Department may approve more than one plan for a given hospital or region; however, it shall approve more than two plans for a given hospital only under extraordinary circumstances. In considering plans for certification, the Department shall give consideration to the views of hospitals in the areas involved.

3. The Department may approve an effective date for plan activity no later than 90 days after approval of a plan.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

Case Notes

Memorandum represented agency's interpretation of how elimination of reimbursement methodology impacted utilization review organizations; not "rule making". Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Memorandum assigning "new task" for utilization review organizations it was "rule making". Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Illegal rule-making aspect of Department of Health (DOH) memorandum did not taint interpretive aspect of memorandum. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Partial repeal of Health Care Facilities Planning Act did not eliminate statutory basis for state-qualified utilization review organizations; access to patient records. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Repeal of rate-regulation did not diminish agency's responsibility for medical necessity and efficiency of services. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Provisions describing nonreimbursement functions of state-qualified utilization review organizations; not repealed. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Hospitals were obligated to collect from payors cost of state-regulated utilization review organization services during transition year. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Administrative provision addressing payment for state-regulated utilization review organizations invalidated. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

8:31B-3.81 Payment for utilization review services

(a) Proposal: The Commissioner shall propose to the Commission reasonable adjustments to the Schedule of Rates for all hospitals to which this subchapter is applicable, together with such terms and conditions as may promote efficiency and effectiveness with respect to the health care delivery system, taken as a whole. Consistent with the criteria set forth in N.J.A.C. 8:31B-3.78, such proposal, which shall be based on the Department's review, analysis, and findings as to the reasonableness of cost proposals under N.J.A.C. 8:31B-3.71 through 3.86 shall be broken into the components defined in N.J.A.C. 8:31B-3.71 through 3.86.

(b) Commission approval: Following a hearing pursuant to N.J.A.C. 8:31B-3.78, the Commission shall approve or modify, and direct an appropriate adjustment to the Schedule of Rates to which this provision applies. In accordance

with N.J.A.C. 8:31B-3.87(a)3, each affected hospital shall implement the approved adjustment consistent with the payor selection procedure set forth in (c) below.

(c) Payor selection procedure:

1. Within 30 days of approval by the Commissioner of any plan in accordance with N.J.A.C. 8:31B-3.80 any payor may:

i. Subject to approval according to N.J.A.C. 8:31B-3.80, apply its own qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

ii. Contract directly with a qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

iii. Where delegated review has been approved, contract directly with the qualifying utilization review organization to monitor and assist delegated review conducted by hospitals, and receive an appropriate discount from the overhead and monitoring cost components of the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b); or

iv. Whenever a payor fails to select (c)1i, ii or iii above, it shall be deemed to have elected (c)1ii or iii above, whichever is appropriate, with the qualified utilization review organization responsible for reviewing the greatest proportion of cases in the hospital involved. In the case of (c)1iii above, the payor shall pay the full utilization review adjustment to the hospital, which shall be responsible for remitting the appropriate amount to the qualified utilization review organization on a timely basis.

2. Payors must notify the Department, hospitals, and all qualified utilization review organizations, of their election under (c)1 above in writing. They may change their elections at any time subject to 60 days written notice.

3. Any payor with total utilization among its subscribers or beneficiaries of fewer than 500 days per 1,000 enrollees in the prior calendar year may apply to the Commission for a full discount from the adjustment without exercising (c)1i, ii or iii above, or being subject to (c)1iv above.

Case Notes

Hospitals were obligated to collect from payors cost of state-regulated utilization review organization services during transition year. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

Administrative provision addressing payment for state-regulated utilization review organizations invalidated. Matter of Final Agency Decision by New Jersey Dept. of Health Regarding Utilization and Quality Review for Calendar Year 1993, 273 N.J.Super. 205, 641 A.2d 1043 (A.D.1994).

8:31B-3.82 Performance standards for maintenance of qualification

Within one year after certification, and each subsequent year thereafter, each qualified utilization review organization shall submit, in a form and manner to be prescribed by the Commissioner, such information and data as may be required to adequately assess the performance of such organizations in accordance with N.J.A.C. 8:31B-3.78. Qualification may be terminated on a finding of inadequate performance.

8:31B-3.83 through 8:31B-3.86 (Reserved)**8:31B-3.87 (Reserved)**

Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Section was "Summary report".

8:31B-3.88 through 8:31B-3.90 (Reserved)

SUBCHAPTER 4. FINANCIAL ELEMENTS AND REPORTING

8:31B-4.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a standardized system of reporting the financial elements to be used in conjunction with the Hospital Reporting of Uniform Bill-Patient Summaries regulation (N.J.A.C. 8:31B-2), the Financial Reporting and Monitoring regulation (N.J.A.C. 8:31B-3) and the Uniform Cost Reporting rule (N.J.A.C. 8:31A-5.5) for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160.

(b) The Commissioner shall require each general acute care hospital to report cost, revenue and statistical information in accordance with the uniform system described in this subchapter. This information is critical and is required to support the Department's public health activities which include planning, licensing, providing information to consumers and other interested parties and monitoring hospital costs and revenues.

PART I. REPORTING PRINCIPLES AND CONCEPTS

8:31B-4.2 Functional versus responsibility reporting

(a) A prerequisite for the informed review of hospital data is good communication, i.e., a common understanding and use of terminology among all parties. Imperfect communication results when terms such as "hours", "dietary", "purchased services", etc. mean different things to different people. The objective in the design of this manual is to achieve uniform reporting of financial elements consistent with uniform definitions of functional cost and revenue centers, statistical data, patient data and the natural classifications of expenses, i.e., salaries, supplies.

(b) Expenses, revenues and other data reported in a manner consistent with the definitions included herein will provide a sound basis for the establishment of a uniform system of reporting. This manual, however, is not requiring that institutions adopt this functional reporting system for their internal management reports, so long as institutions maintain the ability to report data with reasonable accuracy in accordance with the functional definitions and expense and revenue classifications defined herein.

(c) A hospital should structure its accounts for the purpose of managing a sound cost-effective and financially viable organization. In many instances, principally due to various budgetary control objectives, this goal may be better achieved through recording of expenses and revenues on a responsibility basis. However, it is highly unlikely that expenses and revenues recorded on a responsibility basis can be reported "as is" on the prescribed uniformed functional basis. This will necessitate the recast of expenses, revenue and statistics per N.J.A.C. 8:31B-4. Various reporting schedules provide the hospital with the opportunity to insure that the financial data used to develop the financial elements of the current Cost Base, despite the recasts and allocations involved, are equivalent to the hospital's own audited financial statements. A working knowledge of the principles, concepts and definitions included herein, especially with regard to the inclusion of specific functions within reporting centers and of the natural classifications of expense, is necessary for a hospital's accurate compliance with these reporting requirements.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.3 Prescribed reporting principles

(a) The reporting principles and concepts described in this chapter have been drawn from existing systems wherever possible.

(b) Any reporting principles and concepts not specifically discussed in this manual should be reported according to Generally Accepted Accounting Principles as interpreted in the opinions of the American Institute of Certified Public Accountants (AICPA) and in the statements by the Financial Accounting Standards Board (FASB).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.4 Accounting entity

A fundamental reporting concept is that of the accounting entity or unit. For reporting purposes, the hospital is an entity capable of buying, selling and taking other economic action, which are to be accounted for separately from the personal affairs of those responsible for the hospital's administration. The hospital itself is the primary unit for which the accounting records are maintained. Many departments of the hospital assume sufficient importance to require separate treatment as subordinate entities or units of accountability for planning and control purposes.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.5 Continuity of activity

Another basic reporting concept is that of continuity of activity, or the going concern. The assumption is that the hospital will continue to function indefinitely. It then becomes necessary to divide the life of the hospital into reporting periods, to determine revenues earned and expenses incurred during each period and to measure the amounts of assets and obligations at the end of each period.

8:31B-4.6 Reporting period

(a) The basic reporting period is the 12 consecutive calendar months utilized for Medicare.

(b) New hospitals beginning operations on any day other than January 1 must select an initial reporting period beginning on the first day of operation, through the last month preceding the hospital's fiscal year. For example, a hospital beginning operations August 15, 1979 would have an initial reporting period running from August 15, 1979 through December 31, 1979 if it were on a calendar year. Its next reporting period would then be January 1 to December 31.

(c) Each calendar year's Acute Care Hospital Cost Reports as defined in N.J.A.C. 8:31B-4.131 are due on June 30 of the following year. Each year's Audited Financial Statement is due on June 30 of the following year. Failure to meet these time frames will result in penalties as stated in N.J.A.C. 8:31B-3.3.

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(c) added.

Amended by R.1984 d.500, effective November 5, 1984.
See: 16 N.J.R. 2326(a), 16 N.J.R. 3019(b).

Financial report forms and Statement due date changed from April 30 and June 30 to May 31.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

In (c), rewrote the first sentence.

8:31B-4.7 Objective evidence

(a) Information produced by the accounting process should be based, to the extent possible, upon objectively determined facts. Transactions should be supported by properly executed documents such as charge slips, purchase orders, suppliers' invoices, cancelled checks, etc. Such documents serve as objective evidence of transactions and should be retained as a source of verification of the data in the accounting records.

(b) Certain determinations that enter into accounting records are based on estimates. Such estimates should be based on past experience modified by expected future considerations. Examples would include recognition of estimated provisions for bad debts and self-insurance funding and the reporting of other operating expenses separately from

Costs Related to Patient Care. Items of Other Operating Expenses, if not directly classified by the hospital, if large in amount, must be identified through a cost study, and if small in amount, costs may be deemed equal to revenue and such costs apportioned among the appropriate natural classifications of expense based on the hospital's estimate or the classifications of the center where originating. Worksheets are provided along with Reporting Schedules to aid the hospital in making all appropriate reclassifications. All such reclassifications should be consistent with the concept of materiality, defined in N.J.A.C. 8:31B-4.11.

(c) Books, papers, records, or other data relevant to matters of hospital ownership, organization, and operation must be maintained. The data must be maintained in an ongoing recordkeeping system which allows the data to be readily verified by qualified auditors.

8:31B-4.8 Conservatism

Conservatism is a quality of judgement to be exercised in evaluating the uncertainties and risks present in the hospital entity to assure that reasonable provisions are made for potential losses in the realization of recorded assets and in the settlement of actual and contingent liabilities. However, conservatism is not justification for excessively high or low estimates.

8:31B-4.9 Consistency

(a) Consistency refers to continued uniformity during a period and from one period to another in methods of accounting, mainly in valuation bases and methods of accrual, as reflected in the financial statements of an accounting entity. Consistency is very important to the development and analysis of trends on a year to year basis and as a means of forecasting. However, consistency does not require continued adherence to a suboptimal method or procedure. Any change of accounting procedure, consistent with the materiality principal, must be brought to the attention of the Department of Health and Senior Services by way of a cover letter which will accompany the hospital's Financial Elements Report to include both a description and analysis of reporting impact of such accounting procedure changes.

(b) As an example, the accounting principal of accrual reporting (see N.J.A.C. 8:31B-4.13) may cause some hospitals who currently account for vacation on a cash basis to incur a one time reporting of expenses related to vacation time earned by employees but not yet taken. Such one time costs must be included in a cover letter and the Financial Elements Report shall identify only those vacations costs accrued in the current reporting period.

(c) Any accounting and reporting changes due to subsequent revisions of this manual or the documents referred to herein will be reported in accordance with the instructions which accompany those revisions.

Amended by R.2000 d.339, effective August 21, 2000.

See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

8:31B-4.10 Full disclosure

The concept of full disclosure requires that all significant data be clearly and completely reflected in accounting reports. If, for example, a hospital were to change its method of accounting for certain transactions, within the limitations of this manual, and if the change had a material effect on the reported financial position, or operating results, the nature of the change in method and its effect must be disclosed when reporting costs. No fact that would influence the decisions of management, the governing board, or other users of financial statements should be omitted from or concealed in accounting reports.

8:31B-4.11 Materiality

Materiality is an elusive concept with the dividing line between material and immaterial amounts subject to interpretation. It is clear, however, that an amount is material if its exclusion from the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements.

8:31B-4.12 Basis of valuation

(a) Historical cost is the basis used in accounting for the valuation of all assets and in recording all expenses (except fair market value in the case of donated non-cash goods and services). Historical cost, simply defined, is the amount of cash or cash equivalents given in exchange for properties or services at the time of acquisition. It is the basis for the valuation of assets and for the recording of most expenses. Cost ordinarily has been the basis of accounting for assets and expenses because it is a permanent and objective measurement that reflects the accountability of management for the utilization of hospital funds.

(b) Long term investments are to be reported at current market value as noted in N.J.A.C. 8:31B-4.17, with corresponding income or loss reported as realized or unrealized.

(c) Hospitals frequently acquire property, equipment, services and supplies by donation. The property, equipment, service and/or supply is considered donated when acquired without the hospital's making any payment for it in the form of cash, property or service. The property, equipment, service or supply should be valued at acquisition at the fair market value which is the price that the asset would cost by bona fide bargaining between well-informed buyers and sellers at the date of donation (regardless of date of receipt). The fair market value of donated services must be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations may be evidenced by a contractual relationship which may provide the basis for valuation. The amounts recorded are not to exceed those paid others for similar work.

(d) The value of donated goods or services of a type not consistent with the definition given are not included as operating expenses (e.g., donated services of individuals such as volunteers, students and trustees).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.13 Accrual accounting

In order to provide the necessary completeness, accuracy and meaningfulness in reporting data, the accrual basis of accounting is required. Accrual accounting is the recognizing and recording of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time periods in which they apply rather than when cash is received or paid.

8:31B-4.14 Matching of revenues and expenses

(a) Determination of net income for a reporting period requires measurements of revenue, revenue deductions, and expenses associated with the period. Hospital revenue must be recorded in the period in which it is earned; that is, in the time period during which the services are rendered to patients and a legal claim arises for the value of the services.

(b) Once the revenue determination is made, a measurement must be made of the amount of expense incurred in rendering the services on which the revenue determination was based. Unless there is such matching of revenue and expense, the reported gain or loss of a period is meaningless.

(c) It is important that revenue deductions be given reporting recognition in the same period that the related revenues are recorded, even though certain of these revenue deductions cannot be precisely determined until sometime after the end of the reporting period.

(d) Expenses and revenues are to be matched not only for the hospital as a whole, but also for each cost and revenue center. The cost (revenue) center is an accounting device for accumulating items of cost (revenue) that have common characteristics. A cost center may or may not be a department within the hospital. A cost center such as utilities is an example where the cost center would not be a department of the hospital. The costs of the functions and activities included in each cost center description (see N.J.A.C. 8:31B-4 Part vi) are to be included in the cost center. Revenue relative to such functions and activities must be included in the matching revenue center. For example, expenses related to Laboratory are included in the Laboratory cost center and related revenue is to be included in the Laboratory revenue center.

(e) Some hospitals record revenue on an all-inclusive rate basis (a rate based on type of accommodation regardless of the utilization of ancillary services). Utilization of an all-inclusive rate system results only in a modification of the patient billing and revenue accounting system. It does not eliminate the need to report expenses by proper cost center.