

(b) Hospitals that perform organ transplants (with the exception of bone marrow transplants and corneas) must meet the following requirements for participation in the Medicare and Medicaid programs.

1. Payment for transplant services and organ procurement services rendered to or items dispensed or furnished a donor will be considered a charge on behalf of the Medicaid beneficiary .

(c) 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.

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.

(d) 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.

(e) The candidate for transplantation shall have been accepted for the procedure by the transplant center. Such acceptance shall precede a request for prior authorization from the medical staff in the Office of Health Service Administration, if applicable. All out-of-State hospitalizations for transplantations shall require prior authorization from the MDO of the beneficiary's county of residence (see N.J.A.C. 10:49-6.2, Administration.) Prior authorization shall also be required for hospitalizations for procurement and transplantation services for Medicaid beneficiaries for anatomical sites not explicitly listed in (a) above, or previously considered experimental.

(f) 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)).

(g) Hospital inpatient services for an out-of-State organ procurement and transplantation shall require approval by the Medicaid District Office and shall be reimbursed according to the policies in the section on the Basis of Payment—Out-of-State Hospital Services in N.J.A.C. 10:52-4.4.

(h) For organ transplants for Medicaid or NJ KidCare beneficiaries enrolled with a managed care organization, the managed care organization shall be responsible for all costs, except for the costs of the hospital. Included in the hospital costs are the costs of procuring the organ. The hospital should bill the Fiscal Agent for these costs as part of the inpatient hospital claim.

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.

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 or NJ KidCare 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 three hours of participation in active programming for a half day program exclusive of meals and a minimum of five hours of active participation in active programming for a full day program exclusive of meals) in the hospital.

i. Day, evening, or night care (night care shall include overnight stay) shall not require prior authorization from the Division for the first 90 calendar days from the first date of treatment, except that, if partial hospitalization services are being provided to single adults and childless couples who are receiving NJ FamilyCare Plan A services, prior authorization from the Division shall not be required for the first 30 calendar days beginning from the first date of treatment.

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) Prior authorization for PH from the Division shall be required after the first 90 calendar days from the date of the initial treatment, except as provided in (e) below. Each prior authorization for PH shall be granted for a maximum period of six months. Additional authorizations may be requested.

1. A detailed explanation and a new prior authorization request for PH is required when a departure from the plan of care is made because a change in the patient's clinical condition necessitates an increase in the frequency, duration, and intensity of services, or a change in the type of services which will exceed the services authorized.

2. When prior authorization is required, the request shall be submitted on the form, "Request for Authorization of Mental Health Services (FD-07)" to the Psychiatric Consultant, Mental Health Services, Office of the Medical Affairs and Provider Services, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #18, Trenton, New Jersey 08625-0712.

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.

4. The notification of the disposition (approved, modified, denied, or suspended) of the prior authorization request will be made by the Division's fiscal agent. When submitting a claim for reimbursement, the prior authorization number shall be provided on the UB-92 hospital claim form, in order for the claim to be paid by Medicaid/NJ KidCare.

5. The Division shall not reimburse a hospital for partial hospitalization and medical day care center services provided to the same beneficiary on the same day.

6. The Division also shall not reimburse a hospital for any mental health service (including medication management) in addition to partial hospitalization services provided to the same beneficiary on the same day.

(e) If partial hospitalization services are being provided to single adults and childless couples who are receiving NJ FamilyCare Plan A services, prior authorization from the Division shall be required for services provided after the first 30 calendar days from the first date of treatment.

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).

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.

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 or NJ KidCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist. These services include necessary supplies and equipment.

3. "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.

New Rule, R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).

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. 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 of Human Services.

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 Reimbursement Services, PO Box 712, Mail Code #49, 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 and NJ KidCare-Plan A fee-for-service beneficiaries at the rates under appeal even if it were an economically and efficiently operated hospital. Marginal loss is the amount by which a hospital's rate year's Medicaid and NJ KidCare-Plan A fee-for-service reimbursement for inpatient services 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 and NJ KidCare-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 and NJ KidCare-Plan A fee-for-service patients. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid and NJ KidCare-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 and NJ KidCare-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 and NJ KidCare-Plan A fee-for-service beneficiaries or the comparative cost of treating Medicaid and NJ KidCare-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 and NJ KidCare-Plan A fee-for-service beneficiaries) and that the hospital is necessary to provide access to care for Medicaid and NJ KidCare-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.

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.

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, C.A.3 (N.J.)1995, 73 F.3d 509.*

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 (N.J.Super.A.D. 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 (A.D.1994), certification denied 142 N.J. 448, 663 A.2d 1355.*

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.*

SUBCHAPTER 10. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

10:52-10.1 Introduction

(a) The New Jersey Medicaid and NJ KidCare fee-for-service program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). 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 HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three level coding system.

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.

2. LEVEL II CODES (Narratives found at N.J.A.C. 10:52-10.3)

These codes are assigned by HCFA for physicians and non-physician services which are not in CPT.

3. LEVEL III CODES (Narratives found at N.J.A.C. 10:52-10.3)

These codes are assigned by the Division to be used for those services not identified by CPT codes or HCFA assigned codes. Level III codes identify services unique to New Jersey.

(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 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: