



STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES.

HEALTH SERVICES PROGRAM

HOSPITAL MANUAL

J/4/48
I/5/48
1712



August 30, 1974

TO: Hospital Administrators (General)

SUBJECT: Revision to General Hospital Manual

Please replace pages 14, 15, 15.1, 18, 21, 21.1, 23.1, 24, 24.1, 41 and 45 with the attached new page revisions. All new pages effect Chapter II with the exception of page 41, which effects Chapter III. In addition, Exhibit VII - Form FD-07, Request for Authorization of Psychiatric Services is necessary to the General Hospital Manual and has been included.

We strongly urge you to read the attached material since there have been important changes and additions in policy especially as a result of the recent inclusion of Private Psychiatric Hospitals in the New Jersey Medicaid Program and the new procedures relative to Partial Hospitalization Services.

All changes are bracketed on the new page revisions.

Duplicate filed in Medicaid Bulletins (Blue Cross)

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COVERAGE OF HOSPITAL SERVICES

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CHAPTER II

COVERAGE OF HOSPITAL SERVICES

200. DEFINITIONS

200.1 Approved Hospitals

An approved hospital is one which meets all of the following conditions:

- a. Licensed as a general hospital by the New Jersey Department of Institutions and Agencies. (When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a qualified provider); and is
- b. Qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX; and is
- c. Accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the Committee on Hospitals of the American Osteopathic Association; and has
- d. Signed an agreement to participate and abide by the rules and regulations of the Health Services Program.

Hospitals outside the State of New Jersey must meet conditions b and c cited above and be licensed by the appropriate agency under the laws of the respective State.

This section applies to institutions licensed as a general hospital. For policies on institutions licensed as special hospitals see manual on Special Hospitals.

200.2 Inpatient Hospital Services

The term "Inpatient hospital services" means those items and services ordinarily furnished by an approved hospital for the care and treatment of inpatients, which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases.

EXCEPTION: For inpatient psychiatric services provided in an approved private psychiatric hospital see Section 203.8.

COVERAGE OF HOSPITAL SERVICES

200.3 Inpatient

"Inpatient" means a person registered as such for hospital bed occupancy in an Approved Hospital.

200.4 Semi-Private Accommodations

"Semi-Private Room" means a hospital room containing two, three or four beds and classified as semi-private by the hospital.

200.5 Approved Private Psychiatric Hospitals

An approved private psychiatric hospital is one which meets all of the following conditions:

- a. Licensed by the State of New Jersey as a Psychiatric Hospital and is
- b. qualified to participate as a psychiatric hospital under the Title XVIII (Medicare) Program; and/or is
- c. Accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the Committee on Hospitals of the American Osteopathic Association; and has
- d. Signed an agreement to participate and abide by the rules and regulations of the New Jersey Health Services Program.

EXCEPTION: For inpatient psychiatric services provided in an approved private psychiatric hospital see Section 203.8.

200.6 Partial Hospitalization

Partial Hospitalization means a psychiatric service whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities. The service is designed for non-residential patients who spend only a part of a twenty-four hour (three or more hours) period in the hospital. Examples of partial hospitalization facilities are day hospitals and night hospitals. (See Section 205, "Covered Outpatient Hospital Services")

INPATIENT HOSPITAL SERVICES

201. COVERED INPATIENT HOSPITAL SERVICES

Subject to the General limitations and exclusions and those hereinafter specified, hospital care and services shall include:

201.1 Bed and Board in Semi-Private Accommodations

Including special medical dietary services.

Accommodations other than semi-private require certification of medical necessity or lack of availability of semi-private accommodations (See Chapter III, "Explanation of Accommodations").

COVERAGE OF HOSPITAL SERVICES

201.2 General Nursing Services

201.3 Other Medical Services

Services by voluntary or paid hospital employees, by an intern or other physician in training in the hospital, or by a practitioner or other person(s) with whom the hospital contracts to provide eligible services.

201.4 Facilities and Equipment

Use of operating room, recovery room, delivery room, emergency room, intensive care unit, or other special room, including their respective facilities and equipment.

COVERAGE OF HOSPITAL SERVICES

202. NON-COVERED INPATIENT HOSPITAL SERVICES

Benefits are not payable for any services rendered or items dispensed or furnished in connection with:

202.1 Elective Cosmetic Surgery

202.2 Mental Disorders

Any illnesses which according to generally accepted professional standards are not amenable to favorable modification, except that benefits for mental health services shall be available to determine that such disorders or illness are not amenable to favorable modification (e.g., senility).

EXCEPTION: For inpatient psychiatric services provided in an approved private psychiatric hospital see Section 203.8.

202.3 Private Duty Nursing Services

202.4 Items Not Related to Patient Care

Services and supplies not directly related to the care of the patient, such as guest meals and accommodations, television, telephone, and similar items and services. Personal items may be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items.

202.5 Patient Transportation

(Except as stated under Covered Services Section 201.14).

202.6 Research or Teaching Studies

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

202.7 Services Rendered Prior to and After Period of Eligibility

- a. Inpatient hospital services rendered prior to date of application.
- b. Where a Health Services Program recipient in a general hospital loses his eligibility during his hospital stay, the Program will cover the costs of the entire stay. Eligibility on the date of admission or from the date of application (whichever is applicable) carries for the entire length of that hospital stay.

COVERAGE OF HOSPITAL SERVICES

of hospital discharge and must be signed by the attending physician. The Patient Information Transfer Form, Hospital and Nursing Home, adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association (Form No. 767), or equivalent transfer form, may be used.

- b. When an inpatient is to be discharged from the hospital to an Extended Care Facility or Skilled Nursing Home, the Health Services Program will reimburse the receiving facility for up to 30 days without prior authorization by the Program.
- c. When the inpatient is 65 years of age or older, transfer must be to an Extended Care Facility if Medicare (Title XVIII) benefits are available.

203.7 Hospital Benefits in a Non-Approved Hospital

Hospitals which do not meet the definition of an approved hospital are not eligible for payment unless such services are made necessary by reason of accidental injury or sudden and serious illness requiring treatment of an emergency basis. Reimbursement for emergency care shall be limited to a maximum of 20 days.

Claims filed by a non-approved hospital must be accompanied by a statement made by the attending physician, including a description of the nature of the emergency, pertinent clinical information concerning the condition of the patient, and a certification that the services rendered were necessary to prevent the death of the individual or the serious impairment of his health.

203.8 Hospital Benefits in an Approved Private Psychiatric Hospital

The New Jersey Health Services Program recognizes as a covered service medically necessary inpatient services which are provided in an approved private psychiatric hospital to eligible individuals over age 65 and to other eligible individuals prior to:

- the date such eligible individual attains age 21, or
- in the case of an eligible individual who was receiving such services in the period immediately preceding the date on which he attained age 21 (1) the date such individual no longer requires such services or (2) if earlier the date such individual attains age 22.

a. Length of Stay

Reimbursement for inpatient care is based upon the medical necessity of the admission and may not exceed 20 days unless supported by a medical recertification. (Form MC-2)

COVERAGE OF HOSPITAL SERVICES

b. Medical Recertification

Whenever the span of inpatient days exceeds 20, the attending physician is required to certify the necessity of continued hospitalization on or before the expiration of the 20th day. The maximum number of days allowed on the recertification is 20 days. ONLY ONE RECERTIFICATION IS ALLOWABLE FOR EACH ADMISSION (See Sections 307, 308 and 309 of this manual for instructions).

NOTE: In extremely unusual situations where more than 40 days inpatient care is deemed necessary by the attending physician, a special request for continued stay may be submitted no later than the 30th hospital day. The request must specify, in detail why continued hospitalization is necessary for the patient and is to be submitted to:

Chief, Mental Health Services
Division of Medical Assistance
and Health Services
P.O. Box 2486
Trenton, New Jersey 08625

The request must specify the actual number of days for which authorization is requested.

Failure to obtain prior authorization will result in non-payment of the hospital's claim for all days beyond the 40th day and all physicians' claims for the corresponding period will also be denied for payment.

OUTPATIENT HOSPITAL SERVICES

204. OUTPATIENT HOSPITAL SERVICES

Outpatient hospital services are those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in an approved hospital Outpatient Department.

204.1 Outpatient

"Outpatient" means a person registered in the outpatient department in an approved hospital in order to obtain services other than those requiring bed occupancy as an Inpatient.

COVERAGE OF HOSPITAL SERVICES

205.14 Partial Hospitalization

Partial Hospitalization as defined in Section 200.6 of this manual is covered as an outpatient service. Day, evening, or night care (night care must include overnight stay) does not require prior authorization from the New Jersey Division of Medical Assistance and Health Services for the first 30 calendar days. Prior authorization is required for partial hospitalization for each subsequent 30 day period after the first 30 days. (For procedures to obtain prior authorization see Section 207.1C)

206. NON-COVERED OUTPATIENT HOSPITAL SERVICES

Benefits are not payable for any service rendered or items dispensed or furnished in connection with:

206.1 Elective Cosmetic Surgery

206.2 Private Duty Nursing Services

206.3 Services and Supplies Not Related to Patient Care

206.4 Research or Teaching Studies

206.5 Prior Authorization Not Requested Or Denied

Outpatient hospital services rendered prior to the date of application for medical assistance.

Any service or item requiring prior authorization where such authorization has not been obtained or has been denied.

206.6 Any Service, Admission or Item Which is not Medically Required for the Diagnosis or Treatment of a Disease, Injury or Condition.

206.7 Transportation

Transportation including non-emergency ambulance (see Section 205.2 on transportation).

COVERAGE OF HOSPITAL SERVICES

207. SPECIAL PROVISIONS RELATED TO PAYMENT

There is no limitation on the duration or number of visits available to an eligible patient in the outpatient department. However, for the following rehabilitation services, physical therapy, speech therapy occupational therapy, and psychotherapy, a plan of treatment is to be kept on file and should be completed during the patient's initial evaluation visit. Those services which involve an extended course of treatment require that certification for continued need be submitted to the Contractor every 30 days. The certification and/or recertification shall consist of a typewritten statement signed by the prescribing physician which should indicate the type and scope of the procedures to be rendered. The prescription must relate the type, amount, frequency and duration of the therapy services that are to be furnished and must include the diagnosis and anticipated goals. It should be noted that an order for "therapy as needed" will not be accepted. The certification must be completed on a timely basis and the dates on the report must be applicable to the billing dates on the claim submitted.

207.1 Prior Authorization

- a. Special items and services which are not usually part of the outpatient service (e.g., surgical supplies, glasses, custom made limbs and braces, etc.) will require prior authorization. See Section 204, Medical Supplies Manual and Section 203, Vision Care Manual, Section 204, Prosthetics and Orthotics Manual, and Section 204, Hearing Aid Manual.
- b. Procedure for Obtaining Prior Authorization When Dental Services are Other Than Routine

If in the course of the initial examination and development of a treatment plan, services requiring prior authorization are included, then all subsequent services including those defined as routine dentistry, require prior approval. The hospital will submit the treatment plan on the Dental Form (MC-10) with X-rays to the appropriate Dental Field Office for review.

If a treatment plan is developed which requires only routine dentistry, but a treatment change becomes necessary and services requiring prior authorization are indicated, then the routine services to that date may be submitted for payment and the request for additional services must be submitted for approval to the Dental Field Office. A record of care already completed with appropriate X-rays must be included.

- c. Procedure for Obtaining Prior Authorization for Partial Hospitalization

If it is medically determined that the patient will require further partial hospitalization beyond that first 30 calendar days, prior authorization must be obtained from the Chief, Mental Health Services, Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, New Jersey 08625. It is recommended that the hospital

COVERAGE OF HOSPITAL SERVICES

request this authorization on about the 20th day to allow 10 days for processing the authorization by the State and return of same to the hospital.

To request prior authorization, the physician must submit FD-07 (Request For Authorization of Psychiatric Services) in quadruplicate to Chief, Mental Health Services at the above address. All questions must be answered. If authorized, the hospital will receive two copies of the FD-07 from the State with the terms of the authorization. The original FD-07 must be attached to the Contractor copy of the Outpatient Hospital Claim (MC-4) when billing. Authorization will be granted for a maximum of 30 days, therefore, the process must be completed again if further treatment is planned beyond the 60th calendar day.

207.2 Concurrent Care

Services provided to a patient during the same period for the same condition by both private practitioner and outpatient facility, or by two different outpatient facilities, are not covered. Payment will be made only for one service, except in an emergency.

207.3 Free Choice of Transfer

Transfer from one outpatient facility to another or a change from outpatient facility to private practitioner care is allowable, however, every effort should be made to avoid duplication of diagnostic tests and services.

208. SPECIAL PROVISIONS RELATED TO BLOOD--INPATIENT AND OUTPATIENT

Blood may be provided to an inpatient of an approved hospital, an outpatient of an approved hospital, or any approved medical facility when prescribed and supervised by a licensed physician.

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ADMISSION AND BILLING PROCEDURES

309. DISPOSITION OF COPIES OF COMPLETED FORMS MC-2

- A. The original (MC-2-A Contractor's Copy) must be forwarded to the hospital's contractor with Form MC-1 for processing.
- B. The second copy (MC-2-B County Copy) must be mailed to the Local County Medical Assistance Unit.
- C. The third copy (MC-2-C Provider Copy) will be retained by the hospital.
- D. The fourth copy (MC-2-D Utilization Committee Copy) will be forwarded to the provider's Utilization Review Committee for review.

310. BILLING PROCEDURES FOR OUTPATIENT SERVICES--GENERAL

Form MC-4 Outpatient Hospital Billing--will be used by a hospital to report outpatient services.

Under the New Jersey Health Services Program, the hospital must submit this form on a monthly billing cycle. However, separate claim forms will be required for services rendered in different calendar quarters.

Medicare/Medicaid Coverage--When the patient is covered under both programs only a Medicare form (SSA 1483) should be completed, with Item 11 showing the Health Services Program Case and Person Number on that Medicare Form.

Where prior authorization is required for program purposes it must be obtained and submitted with the Medicare billing form.

When billing for partial hospitalization beyond the first 30 calendar days, prior authorization form FD-07 (Exhibit VII) must be attached to the outpatient claim form.

311. COMPLETION OF ITEMS ON FORM MC-4 (Exhibit IV)

Use a typewriter or legible printing for all entries on the form.

Item 1: Patient's Name--Enter the Patient's last name, and first name, as shown on the validation form.

HOSPITAL ADMISSION AND BILLING PROCEDURES

Strength - Enter strength of drug.

Rx Number - Enter Rx number.

Original Rx or Refill - Check one

Date Dispensed - Enter Current date.

314. DISPOSITION OF COMPLETED FORM MC-7

- a. Attach to Outpatient Claim form MC-4A.
- b. Forward with MC-4A to the hospital's contractor for processing.

315. PROCEDURES FOR SUBMITTING CORRECTED INPATIENT AND OUTPATIENT BILLS

The hospital may find that a bill already submitted is incorrect. It is not necessary to submit a corrected Form MC-1 or Form MC-4 unless total charges change by more than \$10.00.

To correct a previously submitted bill, the hospital should reproduce a legible copy of the submitted bill. The necessary corrections should be made in red in the appropriate item. The corrected bill should be marked "Debit--Adjust" in the upper right hand corner, and mailed to the Contractor.

To cancel all the charges on a previously submitted bill, reproduce a legible copy and mark it "Cancel Only" in the upper right margin. An explanation for the correction should be given on the reverse side of the bill, and mailed to the Contractor.

316. EXHIBITS

- I. MC-1-A Inpatient Hospital Claim Form
- II. MC-5 Explanation of Accommodation Furnished Form
- III. MC-2-A Inpatient Recertification Form
- IV. MC-4-A Outpatient Hospital Claim Form
- V. MC-1-C Hospital Admission - Notification Form
- VI. MC-7 Hospital Pharmacy Rx Report
- VII. FD-07 Request for Authorization of Psychiatric Services



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

Duplicate,
PREPARED BY BLUE CROSS

New Jersey Health Services Program NEWSLETTER

Volume 76

February 9, 1976

TO: HOSPITAL ADMINISTRATORS

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS
& TREATMENT (EPSDT) - CLARIFICATION AND
UPDATE OF NEWSLETTER VOL. 50

The Division of Medical Assistance and Health Services, in efforts to improve the federally mandated EPSDT Program has modified the EPSDT Referral Report form (MC-19) from a two-part (Social Services and Provider Copies) to a three-part form, which includes one Social Services copy and two Contractor's copies.

For those providers who have a supply on hand of the two-part form, continue using the form until your supply is depleted. In using the two-part form, you must attach both copies to your Outpatient Claim form (MC-4) when billing.

GENERAL INSTRUCTIONS

1. The MC-19 must accompany the MC-4 Outpatient Claim form when the hospital is billing for an EPSDT Exam. It is not required for follow-up visits, nor is the MC-19 to be submitted more than once per year per patient, as the EPSDT package will not be reimbursable more than one time each year.
2. When billing for EPSDT visits, Clinic Code 27 must be shown in Item 18 of the MC-4. The letters EPSDT are to be inserted in Item 22 of the claim form.
3. If more than one clinic visit during the month is necessary to complete the EPSDT package, only one MC-4 should accompany the MC-19 to cover the monthly period for which you are billing.
4. When the results of the screening indicate a condition other than visual, hearing, dental or lead poisoning, list the body system in section 4 on the MC-19 under other problems (5) and include the diagnosis in Item 22 on the MC-4.
5. All subsequent or follow-up treatment rendered to the EPSDT patient once the EPSDT service has been billed, should be billed in the usual manner with use of regular clinic codes. As noted above, once an MC-19 has been submitted, there is no need to use this form again for follow-up services. However, you should indicate "EPSDT Follow-up," and the appropriate diagnosis in Item 22 of the MC-4.
6. The MC-19 may be generated either by the hospital or by a County Welfare Board or DYFS caseworker.

- If the MC-19 is hospital-generated and screening is initiated by the hospital, only Sections 1 and 4 have to be completed.

(continued)

6. continued,

- If the MC-19 is brought to the hospital by the EPSDT patient on referral by a County Welfare Board or DYFS caseworker, Sections 1 and 3 will have been completed; therefore, the hospital provider completes only Section 4.

7. When the EPSDT service is hospital-generated, the two Contractor's copies of the completed MC-19 must be attached to the MC-4 when billing. The Social Service copy may be retained or destroyed at the option of the hospital.

NOTE: Hospitals may initiate screening examinations without formal requirements involving verification that a child has not been previously screened, although this does not preclude inquiry of the County Welfare Board or the family regarding previous medical examinations.

For further information, please call (201) 456-2570.



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

Duplicate

100-107-1000

New Jersey Health Services Program NEWSLETTER

Volume 77

February 10, 1976

TO: HOSPITAL & SPECIAL HOSPITAL ADMINISTRATORS

SUBJECT: CLARIFICATION OF NEWSLETTER 73

Numerous inquiries have been received regarding the matter of Medicaid reimbursement for medical supplies and equipment provided in hospital and special hospital outpatient departments subsequent to the January 16, 1976 cut-off for certain services.

The purpose of this Newsletter is to clarify the policy regarding such supplies and equipment.

The Medicaid Program will continue to recognize as allowable outpatient charges those medical supply items necessary to treat the injury or illness that brought the patient to the emergency room or outpatient department. (For example, a patient is admitted to the emergency room with a laceration, the sutures and bandages necessary to treat the wound are allowable charges.)

The Medicaid Program will not recognize as allowable charges any of the following:

1. Take Home Supplies
2. Durable Medical Equipment

(For example a patient is treated in the OPD for a broken leg. The casting materials are an allowable charge, but a pair of crutches provided to that patient would not be an allowable charge under the Medicaid Program.)

EXCEPTIONS:

1. Renal Dialysis

Supplies and equipment incident to the provision of Renal Dialysis are an exception to the curtailment of Medicaid reimbursement for medical supplies and equipment.

Reimbursement for such items and supplies remains the same as it was immediately prior to January 16, 1976.

2. The following LIFE SUSTAINING medical supply and equipment items will continue to be reimbursable in the emergency room, outpatient department and from medical supply and equipment dealers:

Oxygen and other Compressed Gases
Oxygen Masks
Oxygen Regulators
Oxygen Cannulas

IPPB Machines
Respirators
Suction Machines
Catheters for Suction Machines

*** SPECIAL NOTE REGARDING HYPODERMIC NEEDLES AND SYRINGES

Since January 1, 1976 hypodermic needles and syringes have been considered to be reimbursable drug items, not Medical Supplies under the New Jersey Medicaid Program. Therefore, these items will continue to be reimbursable as take home drugs in the outpatient setting in accordance with Section 210 of the Hospital and Special Hospital Manual.

Should you or your staff have any questions please contact us at (201) 456-2570.



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

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ORDERED BY BLUE CROSS

New Jersey Health Services Program NEWSLETTER

Volume 78

March 15, 1976

TO: HOSPITAL AND SPECIAL HOSPITAL ADMINISTRATORS

SUBJECT: RESTORATION OF OPTIONAL SERVICES,
PAYMENT FOR NON-LEGEND DRUGS AND
ELIMINATION OF \$.25 CO-PAYMENT
PROVISIONS

The New Jersey Legislature enacted, and Governor Byrne signed on March 8, 1976, an emergency supplemental appropriation enabling the program to restore through June 30, 1976 (the end of this fiscal year), certain reductions Medicaid had been forced to make.

Therefore, please be advised that the outpatient department program reductions described in Newsletters 73 and 77 are restored effective March 8, 1976. Services provided to Medicaid eligibles in the outpatient departments on and after March 8, 1976, will be reimbursable to the same extent and in the same manner as they were prior to January 16, 1976.

This restoration is not retroactive, therefore, the Medicaid Program cannot reimburse providers for the referenced services if they were rendered on and after January 16, 1976, but before March 8, 1976.

Additionally, effective March 8, 1976, the Medicaid Program will resume reimbursement for necessary Non-Legend Drugs provided to Medicaid outpatients through the hospital's pharmacy in the same manner and to the same extent as prior to August 1, 1975. The requirement for the patient's \$.25 per prescription co-payment is eliminated for prescriptions provided on and after March 8, 1976. These pharmaceutical restorations rescind Items 1 and 2 of Newsletters 58 and 65.



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

Duplicate.

New Jersey Health Services Program NEWSLETTER

Volume 73

January 9, 1976

TO: HOSPITAL AND SPECIAL HOSPITAL ADMINISTRATORS

SUBJECT: ELIMINATION OF CERTAIN MEDICAID
SERVICES IN OUTPATIENT DEPARTMENT

Due to the severe shortage of State funds for operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services.

Accordingly, Medicaid reimbursement to the Hospital and Special Hospital Outpatient Departments rendered on and after January 16, 1976, for the following services will cease unless prior authorized on or before January 15, 1976. All such prior authorized services must be completed by March 15, 1976, and claims for them must be submitted in accordance with standard billing procedures. If any prior authorization services extend beyond March 15, 1976, the Medicaid Program will not reimburse for any service rendered on and after March 16, 1976.

All requests for Prior Authorization received after January 15, 1976, will be declined by the Program.

- Podiatrist, Chiropractor, Psychologist and therapy (e.g. physical, speech and occupational) Services performed in the Hospital Outpatient Department (OPD).
- Orthotic Devices supplied by the Hospital Outpatient Department.
- Medical Supplies and Equipment supplied by the Hospital Outpatient Department.
- Hearing Aids for all eligibles 21 and over supplied by the Hospital Outpatient Department.
- Vision Services performed by Ophthalmologists, Optometrists and Opticians if performed in the Hospital Outpatient Department for eligibles 21 and over. This means that payment will not be made for eye examinations, glasses, contact lenses, vision training, sub normal vision devices for eligibles 21 years and over. Exception: Medical treatment provided by a physician for eye injuries and pathological conditions is reimbursable.

continued

Duplicate.



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

PREPARED BY BLUE CROSS

New Jersey Health Services Program NEWSLETTER

Volume 71

February 1, 1976

TO: HOSPITAL AND SPECIAL HOSPITAL ADMINISTRATORS AND SOCIAL SERVICES DIRECTORS

SUBJECT: A REMINDER: MEDICAID AND THE NEW
JERSEY "NO FAULT" LAW - UNSATISFIED
CLAIM AND JUDGMENT FUND

It has come to our attention through hospital submittal of claims to Medicaid that a reminder is needed regarding services rendered to victims of auto accidents involving uninsured or hit-run drivers. Please advise your Business Office personnel that a Medicaid recipient who is:

- 1) THE VICTIM OF A HIT-RUN ACCIDENT
or
- 2) A PASSENGER IN AN UNINSURED VEHICLE
and
- 3) DOES NOT OWN OR BELONG TO A FAMILY
UNIT THAT OWNS A MOTOR VEHICLE

may be entitled to have payment made on his/her behalf from the Unsatisfied Claim and Judgment Fund (UCJF). The UCJF makes payment based on reasonable charges and within the same time frame as insurance companies making Personal Injury Protection (PIP) Payments. The injured party or his representative must file a "Notice of Intention to Make Claim" within ninety (90) days from the date of the accident. The appropriate forms as well as pamphlets explaining the "Fund" may be obtained by writing to:

Unsatisfied Claim & Judgment Fund
137 East State Street
Trenton, New Jersey 08666

Of course, the New Jersey Medicaid Program will consider payment of claims for injuries received from hit-run accidents or an accident with an uninsured motorist when documentation regarding the denial of benefits from the Unsatisfied Claim and Judgment Fund is attached to either the MC-1 (Inpatient) or MC-4 (Outpatient) Claim Form. This procedure is identified under the General Hospital Manual, Sections 108, item 6 and 110, wherein, New Jersey Medicaid recipients are not entitled to have payment for health services made on their behalf unless all other sources of payment have been exhausted.

Should you or your staff have any questions regarding the above, please telephone your contractor at (201) 456-2570.

AUG 1 1974

To: Hospital Administrator

Re: Medicaid Decline Codes

For the convenience of your Business Office Personnel, we are re-issuing a list of all decline codes utilized by the Medicaid Program.

Please note that the present voucher incorrectly indicates that decline code 74 represents a partial decline due to special circumstances (social necessity). Revised vouchers reflecting code 74 as a partial decline due to medical necessity are being prepared and will be utilized during the month of August. In addition decline code 67 has been expanded to include a decline for outpatient claims whose date(s) of service falls within the period of services reported on an inpatient bill.

Please review the following with all appropriate Business Office personnel:

All decline codes will consist of two digits: The first will indicate whether the entire stay or only a portion of the stay is declined; the second digit will designate the specific reason for the decline.

First Digit - Type of Decline

<u>Code</u>	<u>Explanation</u>
6	Entire stay declined
7	Portion(s) of stay declined

Second Digit - Reason for Decline

<u>Code</u>	<u>Explanation</u>
0	Workmen's Compensation & other insurance
1	Ineligible at time services rendered

*duplicate filed
in Medicaid Bulletin
(Blue Cross)*

Admitting & Billing

BH-15

<u>Code</u>	<u>Explanation</u>
2	Duplicate claim
3	Non-covered inpatient services, including: Elective cosmetic surgery; Mental disorder; Dental Service; Obesity
4	Services rendered prior to/after day medically necessary including: Custodial care; Diagnostic Admissions
5	Special circumstances (social necessity)
6	Outpatient services rendered after period of eligibility
7	Non-covered outpatient hospital services including: All transportation except ambulance services which are medically necessary: Elective cosmetic surgery; Private duty nursing services; Services and supplies not related to patient care; Research or teaching studies; Prior authorization not requested or denied; and Any service, admission or item which is not medically required for diagnosis of treatment of a disease, injury or condition. Outpatient claim submitted whose date(s) of service fall within the period of services reported on an inpatient claim
8	AID Decline
9	Claim over 24 months old

Examples:

Decline Code

63	Entire decline for a non-covered inpatient service
69	Entire stay decline, over 24 months
75	Portion of claim declined due to special circumstances (social necessity).

Should you have any questions concerning the above, please contact us at (201) 456-2570.



NEW JERSEY HEALTH SERVICES PROGRAM

P. O. BOX 700 · NEWARK · NEW JERSEY 07101

January 22, 1973

To: Special Hospital Administrators

Re: Medicaid Manual Revisions

Please review the enclosed revisions to the New Jersey Health Services Program Special Hospital Manual.

Your attention is directed to the changes in Prior Authorization procedures for both Class B and Class C facilities. These revisions become effective February 1, 1973.

Please instruct your personnel to destroy the old pages and insert the revisions in the appropriate place.

Should you have any questions regarding the enclosed revisions, please contact us at (201) 456-2570.

HOSPITAL SERVICE PLAN OF NEW JERSEY

NEW JERSEY BLUE CROSS PLAN



23 Washington Street • Newark • New Jersey 07102

MEDICAID BULLETIN

December 1, 1973

To: Hospital Administrators (Special)

Re: Manual Revisions

Enclosed are two sets of Manual Revisions which are effective December 1, 1973. Replace the following pages with those indicated:

Replace Page	With Page	Replace Page	With Page	Replace Page	With Page	Replace Page	With Page
12	12	24	24	38	38	44	44
13	13	24.1	24.1	40	40	Exh.I	Exh.I
19	19 & 19.1	25	25, 25.1, 25.2	41	41	Exh.IV	Exh.IV
21	21	31	31	42	42		
22	22	37	37	43	43		

Please review these revisions paying particular attention to:

1. Outpatient extended course of treatment certifications.
2. The Motor Vehicle accident question on each claim form.
3. The request for the "Plan of Treatment established date" now included on the MC-4.

Continue to use your current supply of in and outpatient forms but include the new information required in items 25 and 26 of the MC-1 and items 18, 24, and 25 of the MC-4. With your next regular order you will receive the new form (s)

If there are any questions concerning these revisions or if you require additional sets please contact us at (201) 456-2570.

duplicate filed in Medicaid Bulletin (B.C.)

MANUAL REVISIONS



MEDICAID BULLETIN

November 9, 1972

To: Hospital Administrators

Re: New Jersey Health Services
Manual Revision

Three copies of revised pages for the New Jersey Health Services Program (Medicaid) Hospital Manual have been enclosed. The old pages should be removed and the revisions inserted in their place. Section 206.7 Transportation, should also be deleted from page 23.1. ? p. 23

The revision contained in Section 205.2 Emergency Room Services, Including Ambulance becomes effective November 1, 1972. Please review the revision regarding emergency and non-emergency ambulance services with the appropriate personnel.

If there are any questions concerning the revised pages, please contact us at (201) 456-2570.

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RECEIVED

NOV 10 1972

Division of State Library
Archives and History
Trenton, N. J.

* NEW:
p. 12
p. 22
p. 22.1

DUPLICATE FILED IN MEDICAID BULLETINS

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

February 14, 1972

ATTENTION: HOSPITAL ADMINISTRATORS AND PRACTITIONERS

THIS NEWSLETTER SUPERSEDES NEWSLETTER NO. 24 FOR HOSPITALS AND IS NEW INFORMATION FOR PRACTITIONERS. Underlines indicate revised material.

HOSPITAL CLAIMS REVIEW

The Hospital Service Plan of New Jersey and the Prudential Insurance Company, Contractors for the New Jersey Health Services Program, are required to perform a detailed medical review of inpatient and outpatient hospital claims to assure reimbursement only for services and/or hospital stays judged to fall within the parameters of Sections 202 and 206 of the Hospital Manual. All hospitals should review both of these sections carefully.

Please take notice of the change to Section 202.9, per the attached revised manual pages, which deletes reference to the hospital obtaining prior authorization from the Local Medical Assistance Unit for services rendered after day medically necessary. This policy no longer applies.

If following an initial "medical review" of the Inpatient or Outpatient Claim, all or any portion of the services rendered appear to be non-covered as defined in Section 202 and/or 206 of the Hospital Manual, the Contractor will notify the hospital in writing of this fact and request that specific information to fully evaluate the claim be forwarded within 21 days from the date of written notification. If the information is not received by the Contractor within the specified time, the case will be declined.

At this time, the hospital must provide all documentation necessary to support their claim. If after review of this additional information, the Contractor, with appropriate medical counsel, determines that all or any portion of the claim is not for covered services, payment will be reduced or denied.

Whenever all or any portion of the hospital claim is denied for payment, the attending physician's claim for services rendered during the corresponding period will also be reviewed for payment.

There will be no additional opportunity for the hospital to request a re-review after claim denial. (See Fair Hearing)

Program regulations prohibit the provider from billing the patient for any portion of the claim that has been denied.

FAIR HEARING

If a hospital or practitioner disagrees with the Contractor's determination to deny all or any portion of a claim a Fair Hearing may be requested as outlined in Chapter I, Section 112.

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

August 4, 1971

ATTENTION: HOSPITAL ADMINISTRATORS

HOSPITAL CLAIMS REVIEW

The Hospital Service Plan of New Jersey and the Prudential Insurance Company, Contractors for the New Jersey Health Services Program, are required to perform a detailed medical review of inpatient and outpatient hospital claims to assure reimbursement only for services and/or hospital stays judged to fall within the parameters of Sections 202 and 206 of the Hospital Manual. All hospitals should review both of these sections carefully.

Please take notice of the change to Section 202.9^{*}, per the attached revised manual pages, which deletes reference to the hospital obtaining prior authorization from the Local Medical Assistance Unit for services rendered after day medically necessary. This policy no longer applies.

If following an initial "medical review" of the Inpatient or Outpatient Claim, all or any portion of the services rendered appear to be non-covered as defined in Section 202 and/or 206 of the Hospital Manual, the Contractor will notify the hospital in writing, of this fact and request specific information to fully evaluate the claim.

At this time, the hospital must provide all documentation necessary to support their claim. If after review of this additional information, the Contractor, with appropriate medical counsel, determines that all or any portion of the claim is not for covered services, payment will be reduced or denied.

Whenever all or any portion of the hospital claim is denied for payment, the attending physician's claim for services rendered during the corresponding period will also be reviewed for payment.

There will be no additional opportunity for the hospital to request a re-review after claim denial. (see Fair Hearing)

Program regulations prohibit the provider from billing the patient for any portion of the claim that has been denied.

FAIR HEARING

If a hospital disagrees with the Contractor's determination to deny all or any portion of a claim it may request a Fair Hearing as outlined in Chapter I, Section 112.

In order to request a Fair Hearing the hospital must indicate the reason for requesting the hearing in writing to:

Director
Division of Medical Assistance and Health Services
P. O. Box 2486
Trenton, New Jersey 08625

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NEWSLETTER

NEWSLETTER

* PAGES 19 & 19.1

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

December 28, 1971

ATTENTION: Hospitals

Please replace pages 24 and 25 of your hospital Manual with the attached. This revision pertains to authorization and certification requirements for rehabilitation services rendered in the outpatient department.

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Trenton, N. J.



New Jersey Health Services Program

NEWSLETTER

Volume 3

AUGUST 21, 1970

NEW JERSEY HEALTH SERVICES PROGRAM-
 BULLETIN NO. 3

Re: Provider Manual Revisions - Hospital

Substitute the following revised sections for the same numbered sections that now appear in the appropriate manual:

1. Hospital, Section 200.1

Approved Hospital

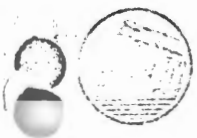
An approved hospital is one which meets all of the following conditions:

- [a. Licensed as a general hospital by the New Jersey Department of Institutions and Agencies. (When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a qualified provider.); and is
- b. Qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX; and is
- c. Accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the Committee on Hospitals of the American Osteopathic Association; and has
- d. Signed an agreement to participate and abide by the rules and regulations of the Health Services Program.

PAGES TO BE REPLACED:

14, 15	24, 25	44, 45
16, 17	26, 27	50, 51
18	36, 37	
20, 21	38	
22, 23	39, 39.1	

DUPPLICATE FILED IN NEWSLETTERS



THE PRUDENTIAL

Insurance Company of America

P.O. Box 1900
MILLVILLE, N. J. 08332
TELEPHONE: (201) 621-6960
(609) 825-8700

Bulletin 10

August 17, 1970

ATTENTION HOSPITAL PROVIDERS:

This publication is intended to provide additional clarification of existing instructions.

A new section has been added on Hospital Pharmacy Reports, MC-7.

Please remove and destroy pages 11-27, 29, 36-39, and 44. Change number on pages 45 to 46, 46 to 47, 47 to 48, 48 to 49, and 49 to 50.

File attached pages 11-27, 29, 36-39, 44, 45, and 51, DATED 7/16/70

FOREWORD

The New Jersey Medical Assistance and Health Services Act (Chapter 413, Laws of 1968) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. This is the New Jersey version of a program commonly known as "Medicaid" or "Title XIX". In identifying persons eligible for such assistance and services this will be known as the New Jersey Health Services Program.

This manual is designed for use by providers billing for services furnished under the Program. It contains informational and procedural material needed to assist the provider in prompt and efficient payment of claims and to answer questions which patients may ask about the program. The procedures described in this manual have been devised to achieve the goals of the Program with due consideration to the needs of the covered persons and effective relationships with providers.

A careful effort has been made to insure that the provisions of the law and the regulations are accurately reflected. This issuance should help to assure that the law is uniformly applied without regard to where covered services are furnished.

The manual is designed to accommodate new pages as administrative changes in procedure are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

	SECTION	PAGE
Who is Eligible.....	100.	2
How to Identify a Covered Person.....	101.	3
Plastic Identification Card.....	101.1	3
Validation Form.....	101.2	3
Temporary Identification and Validation Card.....	101.3	4
Authorized Services for Covered Persons.....	102.	5
Eligible Providers.....	103.	6
Free Choice by Covered Persons.....	104.	6
Contractors.....	105.	7
Prior Authorization.....	106.	7
Policy on Out-of-State Medical Care and Services.....	107.	7
General Exclusions.....	108.	8
Confidentiality of Records.....	109.	9
Utilization of Insurance Benefits.....	110.	9
Medical Review and Evaluation.....	111.	10
Provision for Appeals--Fair Hearings.....	112.	10
Fraud.....	113.	10
Civil Rights.....	114.	10
Observance of Religious Belief.....	115.	10

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Aid to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

GENERAL INFORMATION

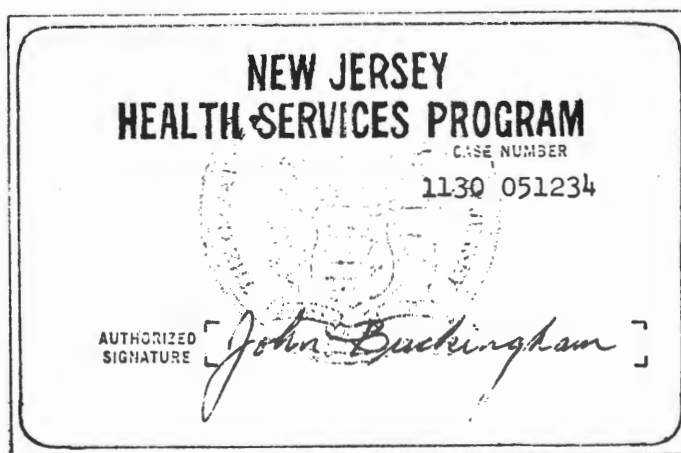
101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

This card identifies an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies. It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OR THE STATE OF NEW JERSEY (SEE SECTION 101.2).

Exhibit I



101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: This form is the sole indicator of eligibility. The plastic identification card alone is not sufficient.

The sample shown contains all of the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, H.S.P. Case Number, and Person Number, EXACTLY as it appears on the Validation form on all Requests for Authorization and claim forms.

102. AUTHORIZED SERVICES FOR COVERED PERSONS

The items and services provided to covered persons will not normally be limited in duration or amount. Any limitations imposed will be consistent with the medical necessity of the patient's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the Division of Medical Assistance and Health Services. The following items and services, more specifically defined in subsequent sections of the appropriate manual, are authorized under the Program:

- (a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;
- (b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;
- (c) Outpatient hospital services;
- (d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;
- (e) Laboratory and x-ray services;
- (f) Skilled nursing home services;
- (g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;
- (h) Other practitioners' services, limited by State law to podiatrists and optometrists;
- (i) Dental services, including dentures;
- (j) Home health care services;
- (k) Pharmaceutical services prescribed drugs (legend and non-legend)
- (l) Prosthetic devices and appliances, medical supplies and equipment; eyeglasses and hearing aids;
- (m) Rehabilitation services;
- (n) Transportation, i.e., ambulance service to and from a medical facility when the patient's condition precludes the use of other means of transportation.

GENERAL INFORMATION

103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, institution, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;
Certified Independent Clinical laboratories;
Dentists;
Hearing Aid Dealers;
Home Health Agencies;
Hospitals;
Skilled Nursing Homes;
Opticians;
Optometrists;
Approved Clinics (Independent Outpatient Health Facilities);
Certified Orthotists;
Pharmacies;
Physicians;
Podiatrists;
Certified Prosthetists;
Providers of Medical Transportation.

104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the Local Medical Assistance Unit may assist in obtaining an appropriate practitioner.

GENERAL INFORMATION

105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical services claims (i.e., legend and non-legend drugs), and claims for out of state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to the Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the program.

106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.

GENERAL INFORMATION

2. When it is customary for the inhabitants of the district generally to use medical care resources and facilities outside the State of New Jersey.
3. When out of state care was provided in an emergency.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;
2. Any services or items furnished in connection with elective cosmetic surgery;

Note: There are certain exceptions to this rule.

A written certification of medical necessity and a treatment plan must be submitted by the physician to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;
4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;
5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;
6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy, any other private or governmental health benefit system, or through any similar third party liability;
7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage;

GENERAL INFORMATION

8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;
9. Any services or items furnished for which the Provider does not normally charge;
10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person's household.

109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which covered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

1. Title XVIII

The Program, in most instances, shall cover the amount of any deductible or co-insurance liability under Title XVIII of the Social Security Act for all covered persons 65 years of age or older.

2. Workmen's Compensation

No Program payments shall be made for a patient covered by workmen's compensation.

3. Other Health Insurance

When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

GENERAL INFORMATION

111. MEDICAL REVIEW AND EVALUATION (by Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

CHAPTER II

COVERAGE OF SPECIAL HOSPITAL SERVICES

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CHAPTER II

COVERAGE OF SPECIAL HOSPITAL SERVICES

200. DEFINITIONS

200.1 Approved Special Hospital

Because of the wide variances of Special Hospitals it is necessary to identify these by three (3) classifications. Each hospital will be required to be listed under one of the classifications and must meet the standards as set forth to qualify as a provider.

All special hospitals would be divided into the following three classifications based on standards for participation and reimbursement:

Classification A. (Acute or Short Term): May be reimbursed on the basis of reasonable costs if all following criteria are met:

1. Licensed as a Special Hospital by the State of New Jersey.
2. Accredited by the Joint Commission on Accreditation of Hospitals as a hospital.
3. Adoption of Approval by Individual Diagnosis (AID) Program.
4. Have departmental cost findings and RCCAC cost allocation capabilities to provide facts for rate determination.
5. Signed agreement to participate in the Health Services Program.

Classification B. (Rehabilitation): May be reimbursed on the basis of reasonable costs if all following criteria are met:

1. Licensed as a Special Hospital by the State of New Jersey.
2. Accredited by the Joint Commission on Accreditation of Hospitals as a hospital or Rehabilitation facility.
3. Adoption of Utilization Review as follows:
21 day recertification by attending physician Active Utilization Review Committee. Prior authorization through Local Medical Assistance Unit or Medicaid's Bureau of Child Health Services* for each additional 30 day period after the first 21 days, with authorizations to list expiration dates. Treatment plan required to support authorization request.

NOTE: See Section 203.4 for procedure on obtaining prior authorization.

4. Have departmental cost findings and RCCAC cost allocation capabilities to provide facts for rate determination.
5. Signed agreement to participate in the Health Services Program.

*Special Hospitals for children are to submit prior authorization requests to: Chief, Bureau of Child Health Services, Division of Medical Assistance & Health Services, P.O. Box 2486, Trenton, New Jersey 08625.

Classification C. (Special Hospital not qualifying to meet the standards of Classification A or B.

Special Hospitals in this classification approved for participation in the Health Services Program must adhere to the skilled nursing home policies and procedures or the classification B Special Hospital regulations e.g. prior authorization for each additional 30 day period after the first 21 days. Reimbursement is based upon a negotiated rate as determined by certified cost information furnished by the special hospital and is limited by the ceiling established for skilled nursing homes under the New Jersey Health Services Program. The following criteria must be met for all Class C Special Hospitals:

1. Licensed as a Special Hospital by the State of New Jersey.
2. Signed agreement to participate in the Health Services Program.
3. Prior authorization as follows:
 - a. For those participating under skilled nursing home procedures:
Prior authorization through the Local Medical Assistance Unit for admission and continued care. Exception: Eligible Medicaid recipients admitted from Acute Care General Hospital or Class A Special Hospital do not require prior authorization for the first 30 days, provided the eligible recipient had been duly admitted as a bed-patient in the hospital for three days immediately preceding the admission to the Class C Special Hospital. Prior authorization is required for payment beyond the 30th day.

These facilities will receive the Skilled Nursing Home Services Manual and must adhere to all rules, regulations and procedures stated therein.

- b. For those participating under Class B Special Hospital procedures:
Prior authorization through Local Medical Assistance Unit or Medicaid's Bureau of Child Health Services* for each additional 30 day period after the first 21 days, with authorizations to list expiration dates. Hospital must submit treatment plan to support authorization request. (See Section 203.4 for procedure on obtaining prior authorizations.

These facilities will receive the Special Hospital Manual and must adhere to all rules, regulations and procedures stated therein.

Special Hospitals for children are to submit prior authorization requests to: Chief, Bureau of Child Health Services, Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, New Jersey 08625.

200.2 Special Hospitals Outside the State

Special Hospitals outside the State of New Jersey must be licensed by the appropriate agency under the laws of the respective state and must meet the requirements of Number 2 and 3 under Classification A or B or Number 3 under Classification C, whichever is applicable.

200.3 Inpatient Hospital Services

The term "Inpatient Hospital Services" means those items and services ordinarily furnished by an approved special hospital for the care and treatment of inpatients which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases.

CHAPTER II
COVERAGE OF HOSPITAL SERVICES

200. DEFINITIONS

200.1 Approved Hospital

An approved hospital is one which meets all of the following conditions:

- a. Licensed as a general hospital by the New Jersey Department of Institutions and Agencies. (When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a qualified provider.); and is
- b. Qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX; and is
- c. Accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the Committee on Hospitals of the American Osteopathic Association; and has
- d. Signed an agreement to participate and abide by the rules and regulations of the Health Services Program.

Hospitals outside the State of New Jersey must meet conditions b and c cited above and be licensed by the appropriate agency under the laws of the respective State.

This section applies to institutions licensed as a general hospital. For policies on institutions licensed as special hospitals see manual on Special Hospitals.

200.2 Inpatient Hospital Services

The term "Inpatient hospital services" means those items and services ordinarily furnished by an approved hospital for the care and treatment of inpatients, which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases.

COVERAGE OF HOSPITAL SERVICES

200.3 Inpatient

"Inpatient" means a person registered as such for hospital bed occupancy in an Approved Hospital.

200.4 Semi-Private Accommodations

"Semi-Private Room" means a hospital room containing two, three or four beds and classified as semi-private by the hospital.

INPATIENT HOSPITAL SERVICES

201. COVERED INPATIENT HOSPITAL SERVICES

Subject to the General limitations and exclusions and those hereinafter specified, hospital care and services shall include:

201.1 Bed and Board in Semi-Private Accommodations

Including special medical dietary services.

Accommodations other than semi-private require certification of medical necessity or lack of availability of semi-private accommodations (See Chapter III, "Explanation of Accommodations").

201.2 General Nursing Services

201.3 Other Medical Services

Services by voluntary or paid hospital employees, by an intern or other physician in training in the hospital, or by a practitioner or other person(s) with whom the hospital contracts to provide eligible services.

201.4 Facilities and Equipment

Use of operating room, recovery room, delivery room, emergency room, intensive care unit, or other special room, including their respective facilities and equipment.

201.5 Supplies

Therapeutic solutions, all types of anesthetic agents, oxygen, serums, dressings, surgical supplies, bandages, plaster casts and splints.

201.6 Drugs and Biologicals

All drugs, medicines and medications customarily supplied by the hospital or which, at the time prescribed, are in commercial production and commercially available to the hospital and have been listed or accepted for listing by any one of the following publications:

"United States Pharmacopoeia," "Homeopathic Pharmacopoeia of the United States," "National Formulary," "New and Non-Official Drugs" and "Accepted Dental Therapeutics."

201.7 Blood

Whole blood, and/or derivatives, and necessary processing and administration thereof, when not otherwise available (See Section 208).

201.8 Rehabilitation Services

Rehabilitation medicine services including therapy by physical medicine, occupational therapy and other restorative services.

201.9 Diagnostic X-ray

Diagnostic use of X-ray or radioactive isotopes.

201.10 Radiation Therapy

Including teleradiotherapy, radioactive isotope therapy (non-sealed sources) administered internally, radium and radioisotopes (sealed sources).

201.11 Laboratory Examinations and Diagnostic Studies

Shall include diagnostic laboratory examinations and clinical tests, such as electrocardiograms, electroencephalograms, echoencephalograms, and other similar clinical tests.

201.12 Prosthetic Devices

Required to complete a surgical procedure including pacemakers. (Excluding artificial limbs, custom made braces, dentures and artificial eyes).

COVERAGE OF HOSPITAL SERVICES

201.13 Maternity

Maternity services are those relating to any admission for: childbirth; care related to pregnancy or childbirth; or any disease, injury or condition incident to pregnancy or childbirth. Such maternity services shall also include any concurrent services in the hospital to the newborn during the initial eligible joint hospital stay of the mother and newborn.

201.14 Ambulance

Hospital based emergency ambulance service which results in inpatient admission.

201.15 Services in Connection with Dental Conditions

Inpatient hospital services for dental conditions provided that:

- a. The services are necessary because of accidental injury, or
- b. The patient is admitted for extraction of one or more impacted teeth, or treatment of malignancy of the mouth, or oral surgery, or
- c. The patient is admitted for extraction of one or more teeth, and a physician certifies in writing that hospitalization is medically necessary for the health of the patient because of a specified organic complication, or
- d. The patient is admitted for an eligible non-dental condition and dental services are rendered (a) as part of the prescribed treatment for such condition, or (b) to alleviate the patient's discomfort during the period of hospitalization for such condition.

201.16 Renal Dialysis and Renal Transplant

- a. Reimbursement for renal dialysis and renal transplant shall be made only to Centers approved by the New Jersey Department of Health. (See Health Services Program Bulletin No. 3, Policy on Renal Dialysis dated May 18, 1970).
- b. In renal transplant, reimbursement for services rendered to or items dispensed or furnished a donor will be considered a charge on behalf of the eligible recipient.

201.17 Other Hospital Facilities

All other hospital facilities and equipment ordinarily provided for care and treatment of inpatients and not specifically excluded.

COVERAGE OF HOSPITAL SERVICES

202. NON-COVERED INPATIENT HOSPITAL SERVICES

Benefits are not payable for any services rendered or items dispensed or furnished in connection with:

202.1 Elective Cosmetic Surgery

202.2 Mental Disorders

Any illnesses which according to generally accepted professional standards are not amenable to favorable modification, except that benefits for mental health services shall be available to determine that such disorders or illness are not amenable to favorable modification (e.g., senility).

202.3 Private Duty Nursing Services

202.4 Items Not Related to Patient Care

Services and supplies not directly related to the care of the patient, such as guest meals and accommodations, television, telephone, and similar items and services. Personal items may be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items.

202.5 Patient Transportation

(Except as stated under Covered Services Section 201.14.)

202.6 Research or Teaching Studies

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

202.7 Services Rendered Prior to and After Period of Eligibility

- a. Inpatient hospital services rendered prior to date of application.
- b. Where a Health Services Program recipient in a general hospital loses his eligibility during his hospital stay, the Program will cover the costs of the entire stay. Eligibility on the date of admission or from the date of application (whichever is applicable) carries for the entire length of that hospital stay.

COVERAGE OF HOSPITAL SERVICES

202.8 Services Rendered Prior to Day Medically Necessary

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

202.9 Services Rendered After Day Medically Necessary

Inpatient hospital services rendered after the day it is medically necessary, except when special circumstances prevent the discharge or transfer of the patient.

NOTE: The Contractors may reimburse a hospital up to 12 calendar days following the period established as being medically necessary if special circumstances (social necessity) prevent the discharge or transfer of the patient to his/her home, sheltered boarding home or intermediate care facility, and the hospital has taken effective action to stimulate placement of the patient.

Effective action is defined as telephone notification to the County Welfare Board, Bureau of Children Services District Office or other responsible officials within one working day of the time that the stay has been determined to be no longer medically necessary. This telephone contact must be then confirmed in writing.

A copy of the written notification must be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).

Payment for Special Circumstances (Social Necessity) is specifically precluded for:

- a. Patients awaiting placement in an Extended Care Facility.
Exception: Payment for three calendar days of inpatient hospital services after the date the hospital utilization review committee notifies the attending physician and patient that further stay is not medically necessary is allowed if effective action, as defined above, is demonstrated.
- b. Patients awaiting placement in a Skilled Nursing Home.
- c. Patients for whom a claim has been denied for lack of medical necessity.
- d. Patients who were not eligible recipients as of the date of admission.

202.10 Admissions Primarily for Rest Cure, Custodial or Convalescent Care, etc.

Rest cure, custodial, convalescent or sanatorium care, diet therapy for exogenous obesity;

COVERAGE OF HOSPITAL SERVICES

Diagnostic procedures which can be done on an outpatient or out-of-hospital basis, including but not limited to laboratory tests, electrocardiograms, and diagnostic X-rays;

Any condition for which hospitalization is not medically necessary.

202.11 Services Which Are Billed By and Payable to Another Provider

202.12 Items Not Normally Charged to Patient

Any services or items furnished for which the hospital does not normally charge.

202.13 Prior Authorization Not Obtained or Denied

Any service or item requiring prior authorization where authorization has not been obtained, or has been denied.

202.14 Any service, item which is not medically required for the diagnosis or treatment of a disease, injury or condition

203. SPECIAL PROVISIONS

Entitlement to payment for each continuous period of hospitalization is subject to the following:

203.1 Notification of Admission

The hospital is responsible to give notice of admission to the Local Medical Assistance Unit within two (2) working days following admission. (See Section 304 for instructions.)

203.2 Medical Certification

The admitting (attending) physician is required to certify concerning the reasons for admission. This requirement shall be considered to be satisfied when the admitting form, including diagnosis(es) is completed by the hospital and signed by the physician.

203.3 Approval by Individual Diagnosis - AID Program

The AID Program (Approval by Individual Diagnosis) is a system whereby the initial number of days of hospitalization approved depends on the diagnosed condition for which the patient is treated. Instructions for determining number of days allowed are contained in the AID Manual.

203.4 Medical Recertification

Whenever the span of inpatient days allowed under AID is exceeded, the attending physician is required to certify the necessity of continued hospitalization on or before the expiration of the AID days. Use Inpatient Recertification Form (MC-2). (See Section 309 of this Manual for instructions.)

The physician's recertification is considered approval of additional days, however the maximum days allowed may not exceed those initially allowed under AID. Subsequent recertifications are required if hospitalization is medically necessary beyond this additional period.

203.5 Utilization Review

The hospital is required to meet the requirements of Title XVIII concerning utilization review for all medical assistance patients.

203.6 Discharge Planning

- a. When an inpatient is to be discharged from the hospital and continuing medical care is required, either in another medical facility (i.e., Extended Care Facility, Skilled Nursing Home, Special Hospital) or by a community health agency (e.g., Home Health Agency), the hospital is responsible for providing the facility or agency with a legible abstract or summary of the patient's care while hospitalized and recommendations for further medical care. This information shall be provided at the time

COVERAGE OF HOSPITAL SERVICES

of hospital discharge and must be signed by the attending physician. Copies of the transfer form shall also be sent to the Local Medical Assistance Unit. (See Section 304 for instructions.) The Patient Information Transfer Form, Hospital and Nursing Home, adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association (Form No. 766), or equivalent transfer form, may be used.

- b. When an inpatient is to be discharged from the hospital to an Extended Care Facility or Skilled Nursing Home, the Health Services Program will reimburse the receiving facility for up to 30 days without prior authorization by the Program.
- c. When the inpatient is 65 years of age or older, transfer must be to an Extended Care Facility if Medicare (Title XVIII) benefits are available.

203.7 Hospital Benefits in a Non-Approved Hospital

Hospitals which do not meet the definition of an approved hospital are not eligible for payment unless such services are made necessary by reason of accidental injury or sudden and serious illness requiring treatment on an emergency basis. Reimbursement for emergency care shall be limited to a maximum of 20 days.

Claims filed by a non-approved hospital must be accompanied by a statement made by the attending physician, including a description of the nature of the emergency, pertinent clinical information concerning the condition of the patient, and a certification that the services rendered were necessary to prevent the death of the individual or the serious impairment of his health.

OUTPATIENT HOSPITAL SERVICES

204. OUTPATIENT HOSPITAL SERVICES

Outpatient hospital services are those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in an approved hospital Outpatient Department.

204.1 Outpatient

"Outpatient" means a person registered in the outpatient department in an approved hospital in order to obtain services other than those requiring bed occupancy as an Inpatient.

COVERAGE OF HOSPITAL SERVICES

203.6 Discharge Planning

- A. When an inpatient is to be discharged from the special hospital and continuing medical care is required, either in another medical facility (i.e., Extended Care Facility, Skilled Nursing Home, General Hospital) or by a community health agency (e.g., Home Health Agency), the hospital is responsible for providing the facility or agency with a legible abstract or summary of the patient's care while hospitalized and recommendations for further medical care. This information shall be provided at the time of hospital discharge and must be signed by the attending physician. The Patient Information Transfer Form, Hospital and Nursing Home, adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association (Form #766), or equivalent transfer form, may be used.
- B. When an inpatient is to be discharged from an Acute Care or Short Term Hospital (Class A) to a Skilled Nursing Facility, the Health Services Program will reimburse the receiving facility for up to 30 days without prior authorization by the Program.
- C. When the inpatient is 65 years of age or older, transfer must be to an Extended Care Facility if Medicare (Title XVIII) benefits are available.

203.7 Hospital Benefits in a Non-Approved Hospital

Hospitals which do not meet the definition of an approved hospital are not eligible for payment unless such services are made necessary by reason of accidental injury or sudden and serious illness requiring treatment on an emergency basis. Reimbursement for emergency care shall be limited to a maximum of 20 days.

Claims filed by a non-approved hospital must be accompanied by a statement made by the attending physician, including a description of the nature of the emergency, pertinent clinical information concerning the condition of the patient, and a certification that the services rendered were necessary to prevent the death of the individual or the serious impairment of his health.

COVERAGE OF HOSPITAL SERVICES

205. COVERED OUTPATIENT HOSPITAL SERVICES

Approved special hospital outpatient departments may provide the following services to outpatients when medically necessary.

205.1 Examination and Treatment

By a physician, dentist, or other practitioner eligible to participate in the New Jersey Health Services Program.

205.2 Emergency Room Services, Including Ambulance

Hospital based ambulance services in "emergency conditions" when the outpatient is not subsequently admitted. "Emergency Condition" is defined as a critical illness or injury status for which prompt medical care may be crucial to saving life and limb.

Non-emergency ambulance service is a covered service only when it is ordered by a physician and is medically necessary. A physician's written order stating that any other method of transportation is medically contraindicated must accompany the claim.

205.3 Diagnostic or Therapeutic Radiology

205.4 Laboratory Examinations and Diagnostic Studies

Shall include diagnostic laboratory examinations and clinical tests such as electrocardiograms, electroencephalograms, echoencephalograms, and other similar clinical tests.

205.5 Drugs

Dispensed by the hospital pharmacy. For regulations on take home drugs, see Special Provisions.

205.6 Rehabilitation Services

Physical, occupational, speech therapy and hearing services (See Section 209).

205.7 Psychiatric Services

Including psychological testing.

205.8 Supplies

Necessary for the diagnosis and treatment of the condition for which the hospital outpatient services are required, and ordinarily furnished to an outpatient.

205.9 Blood

Whole blood and/or derivatives, and necessary processing and administration thereof, when not otherwise available (See Section 208).

COVERAGE OF HOSPITAL SERVICES

205. COVERED OUTPATIENT HOSPITAL SERVICES

Approved hospital outpatient departments may provide the following services to outpatients when medically necessary:

205.1 Examination and Treatment

By a physician, dentist, or other practitioner eligible to participate in the New Jersey Health Services Program.

205.2 Emergency Room Services, Including Ambulance

Hospital based ambulance services when outpatient is not subsequently admitted.

205.3 Diagnostic or Therapeutic Radiology

205.4 Laboratory Examinations and Diagnostic Studies

Shall include diagnostic laboratory examinations and clinical tests such as electrocardiograms, electroencephalograms, echoencephalograms, and other similar clinical tests.

205.5 Drugs

Dispensed by the hospital pharmacy. For regulations on take home drugs, see Special Provisions.

205.6 Rehabilitation Services

Physical, occupational, speech therapy and hearing services (See Section 209).

205.7 Psychiatric Services

Including psychological testing.

205.8 Supplies

Necessary for the diagnosis and treatment of the condition for which the hospital outpatient services are required, and ordinarily furnished to an outpatient.

205.9 Blood

Whole blood and/or derivatives, and necessary processing and administration thereof, when not otherwise available (See Section 208).

COVERAGE OF HOSPITAL SERVICES

205.10 Dental Services

See Dental Manual (Section 234.7) for prior authorization, treatment plan requirements, and proper processing of the REQUEST FOR AUTHORIZATION AND PAYMENT OF DENTAL SERVICES Form (MC-10).

205.11 Outpatient Surgical Procedures

205.12 Other Items or Services

That are medically indicated and provided in the medical management of disease or injury and are ordinarily furnished to an outpatient.

205.13 Family Planning Services

206. NON-COVERED OUTPATIENT HOSPITAL SERVICES

Benefits are not payable for any service rendered or items dispensed or furnished in connection with:

206.1 Elective Cosmetic Surgery

206.2 Private Duty Nursing Services

206.3 Services and Supplies Not Related to Patient Care

206.4 Research or Teaching Studies

206.5 Prior Authorization Not Requested Or Denied

Outpatient hospital services rendered prior to the date of application for medical assistance.

Any service or item requiring prior authorization where such authorization has not been obtained or has been denied.

206.6 Any service, admission or item which is not medically required for the diagnosis or treatment of a disease, injury or condition

~~206.7 Transportation DELETE 11/9/72~~

Transportation including non-emergency ambulance (see Section 205.2 on transportation).

COVERAGE OF HOSPITAL SERVICES

206. NON-COVERED OUTPATIENT HOSPITAL SERVICES

Benefits are not payable for any service rendered or items dispensed or furnished in connection with:

- 206.1: Elective Cosmetic Surgery
- 206.2: Private Duty Nursing Services
- 206.3: Services and Supplies Not Related to Patient Care
- 206.4: Research or Teaching Studies
- 206.5: Prior Authorization Not Requested or Denied

Outpatient hospital services rendered prior to the date of application for medical assistance.

Any service or item requiring prior authorization where such authorization has not been obtained or has been denied.

- 206.6: Any Service, Admission or item which is not medically required for the diagnosis or treatment of a disease, injury or condition

207. SPECIAL PROVISIONS RELATED TO PAYMENT

There is no limitation on the duration or number of visits available to an eligible patient in the outpatient department. However, for the following rehabilitation services, physical therapy, speech therapy occupational therapy, and psychotherapy, a plan of treatment is to be kept on file and should be completed during the patient's initial evaluation visit. Those services which involve an extended course of treatment require that certification for continued need be submitted to the Contractor every 30 days. The certification and or recertification shall consist of a typewritten statement signed by the prescribing physician which should indicate the type and scope of the procedures to be rendered. The prescription must relate the type, amount, frequency and duration of the therapy services that are to be furnished and must include the diagnosis and anticipated goals. It should be noted that an order for "therapy as needed" will not be accepted. The certification must be completed on a timely basis and the dates on the report must be applicable to the billing dates on the claim submitted.

COVERAGE OF HOSPITAL SERVICES

207.1: Prior Authorization

- a. Special items and services which are not usually part of the outpatient service (e.g., surgical supplies, glasses, custom made limbs and braces, etc.) will require prior authorization. See Section 204. Medical Supplies Manual and Section 203.2, Vision Care Manual.
- b. Procedure for Obtaining Prior Authorization When Dental Services are Other Than Routine

If in the course of the initial examination and development of a treatment plan, services requiring prior authorization are included, then all subsequent services including those defined as routine dentistry require prior approval. The hospital will submit the treatment plan on the Dental Form (MC-10) with X-rays to the appropriate Dental Field Office for review.

If a treatment plan is developed which requires only routine dentistry, but a treatment change becomes necessary and services requiring prior authorization are indicated, then the routine services to that date may be submitted for payment and the request for additional services must be submitted for approval at the Dental Field Office. A record of care already completed with appropriate X-rays must be included.

207.2 Concurrent Care

Services provided to a patient during the same period for the same condition by both private practitioner and outpatient facility, or by the two different outpatient facilities, are not covered. Payment will be made only for one service, except in an emergency.

COVERAGE OF HOSPITAL SERVICES

207.3 Free Choice of Transfer

Transfer from one outpatient facility to another or a change from outpatient facility to private practitioner care is allowable, however, every effort should be made to avoid duplication of diagnostic tests and services.

SPECIAL PROVISIONS

208. SPECIAL PROVISIONS RELATED TO BLOOD--INPATIENT AND OUTPATIENT

Blood may be provided to an inpatient of an approved hospital, an outpatient of an approved hospital, or any approved medical facility when prescribed and supervised by a licensed physician.

208.1 Scope of Service

Whole blood, and/or derivatives, and necessary processing and administration thereof, is allowed with the following limitations.

- (a) Efforts should be made to arrange for the replacement of blood. This can be done by contribution of a blood donor, or by using a blood replacement plan that includes the eligible person as a beneficiary (if available).
- (b) The cost of donated blood or blood received through a replacement plan is not reimbursable. However, the charge for cross-matching, indexing, storage and transfusing is reimbursable.
- (c) Certification by the supplier or the facility where the transfusion is given, that voluntary blood donations cannot be obtained is required.

209. REHABILITATION SERVICES - SPECIAL HOSPITAL OUTPATIENT ONLY

209.1 Definitions

- (a) "Rehabilitation services" such as physical therapy, occupational therapy, speech therapy, and hearing services and the use of such supplies and equipment as are necessary in the provision of such services.
- (b) "A qualified physical therapist is one who:
 1. Has graduated from a physical therapy curriculum approved by -
 - a. The American Physical Therapy Association; or
 - b. The Council on Medical Education and Hospitals of the American Medical Association; or

COVERAGE OF HOSPITAL SERVICES

- c. The Council on Medical Education of the American Association in collaboration with the American Physical Therapy Association; or
2. Prior to January 1, 1966 --
 - a. Has been admitted to membership by the American Physical Therapy Association; or
 - b. Has been admitted to registration by the American Registry of Physical Therapists; or
 - c. Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or
 3. If he is currently licensed or registered to practice physical therapy pursuant to State law, he:
 - a. Was licensed or registered prior to January 1, 1970, and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the Public Health Service; or
 - b. Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which he rendered services upon the order of and under the direction of attending and referring physicians; or
 4. If trained outside the United States--
 - a. Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and
 - b. Is a member of a member organization of the World Confederation for Physical Therapy; and
 - c. Has completed 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and
 - d. Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

COVERAGE OF HOSPITAL SERVICES

- (c) A "speech therapist" is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.
- (d) A "qualified occupational therapist" is registered by the American Occupational Therapy Association or is a graduate of a program in occupation therapy approved by the Council on Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

209.2 Scope of Services

This section is concerned with rehabilitation service which includes physical therapy, occupational therapy, speech therapy, and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best functional level. It does not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill or a qualified physical therapist.

Rehabilitation services shall be made available to covered persons as an integral part of a comprehensive medical care program. Such services include not only intermittent or part-time service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

209.3 General Policies

a. Providers of Services

Rehabilitation services shall be provided by qualified therapists employed by or under contract to the Hospital.

EXCLUSION: Rehabilitation services provided by a physical therapist on a private basis are not reimbursable.

b. Where Care May Be Provided

Rehabilitation services may be provided in the patient's home or other place of residence, in a hospital outpatient department, in an approved clinic (independent outpatient health facility not part of a hospital).

c. Prior Authorization (See Section 207.1)

d. Supervision of Therapy

All therapy must be provided under direct personal supervision and in the presence of a qualified therapist or fully licensed physician.

210. TAKE HOME DRUGS--OUTPATIENT ONLY

210.1 Prescription Policies

The program provides payment for take home drugs dispensed by the hospital pharmacy.

COVERAGE OF HOSPITAL SERVICES

The choice of prescription drugs remains at the discretion of the prescribing physician. However, preference should be given to:

1. Drugs listed in the latest edition of the U.S. Pharmacopoeia (U.S.P.), National Formulary (N.F.), New Drugs, and Accepted Dental Therapeutic Remedies.
2. Oral medication when as effective as injectable preparations.
3. Non-proprietary or generic named drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brand-named drugs.

210.2 Non-Reimbursable Prescriptions

Prescriptions will not be eligible for payment under the program in the following instances:

1. Drugs for which adequate literature, i.e. package inserts, etc., and price catalogues are not readily available.
2. Experimental drugs.
3. Drugs and biologicals provided without charge through programs of other public or voluntary agencies (i.e., New Jersey State Department of Health, New Jersey Heart Association, etc., Drug and Biological Listing available from pharmacies).

210.3 Quantity Limitations

The Quantity of Medication prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60-day supply.

- EXCEPT:
1. Oral antibiotics or anti-infective agents may not be prescribed for more than a ten (10) day supply.
 2. Oral contraceptives may be prescribed for up to a three-month supply.

At the decision of the prescribing physician, commonly used sustaining drugs should be prescribed in sufficient quantity to treat the patient for up to sixty (60) days.

210.4 Prescription Requirements

1. All prescriptions should signify in writing the prescribing physician's intentions for refills up to two times. Two refills within a six-month period are eligible for payment (see Exceptions 1 and 2, Section 210.3).

Payment will not be made under the program unless the prescribing physician includes specific directions on all prescriptions ("prn", "as directed", and "ad lib" are examples of non-acceptable directions). This ruling does not apply for prescriptions such as topical preparations, aerosol inhalers or Nitroglycerin tablets since specific directions are seldom possible in these instances.

2. Two refills within a six-month period are eligible for payment. Oral contraceptives for which the prescriber may indicate a three-month supply may be refilled twice within a nine-month period.

CHAPTER III

ADMISSION AND BILLING PROCEDURES

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CHAPTER III

ADMISSION AND BILLING PROCEDURES

300. SUMMARY OF ADMISSION PROCEDURES FOR INPATIENTS

The purpose of this section is to give a brief outline of routine handling of admissions.

300.1 Identification Card and Validation Form

The first step in preparing the Notice of Admission in inpatient cases is to ask the patient for his identification card and validation form.

It is very important that the case number and person number be accurately recorded on the claim form. The case cannot be processed if either of the numbers is missing or incorrect.

(For more detailed information, see Section 101.)

301. INPATIENT HOSPITAL CLAIM (FORM MC-1) (Exhibits I & V)

This 3-part form serves two purposes: (1) To report to the Local Medical Assistance Unit the admission of a covered person who is eligible for medical assistance; (2) To bill the program for the inpatient services rendered.

- Contractor's Copy (MC-1-A) - To be used by Provider when billing the Contractor.
- Provider Copy (MC-1-B) - To be retained by the Provider.
- County Copy (MC-1-C) - This copy must be submitted to the Local Medical Assistance Unit within 48 hours of admission. It is not to be sent to the Contractor.

ADMISSION AND BILLING PROCEDURES

301.1 Completing Inpatient Hospital Claim (Form MC-1)

Use a typewriter or legible printing for all entries on the form.

The following items are to be completed at the time of admission:

Item 1: Patient's Name--Enter the patient's last name, and first name, as shown on the validation form.

Item 2: Sex--Enter "X" in the appropriate block.

Item 3: Birth Date--Enter the patient's birth date by month, day and year. If the date of birth is unknown, transmit the claim form without the date of birth. If only the year of birth is known, show the year. While the date of birth is useful as identification and should be shown when available, a claim will be processed without it.

Item 4: Leave blank.

Item 5: Enter Admission Date.

Item 6-9: Leave blank.

Item 10: Enter Attending Physician's Name.

Item 11: Enter Medical Record Number.

Item 12: Health Services Program Case Number--Enter the covered person's program case number as shown on the identification card or validation form. (See Section 101.)

Item 13: Patient Person Number--Enter the patient person number shown on the validation form. (See Section 101.)

NOTE: In maternity cases, when the child remains in the hospital after the mother is discharged, the hospital must contact the County Welfare Board in order to obtain the child's person number.

Item 14: Enter Provider Name and Address--Abbreviations may be used. This information may be preprinted.

Item 15: Enter Provider Number--This information may be preprinted.

Item 16: Case Name--Enter name as it appears on the permanent identification card.

ADMISSION AND BILLING PROCEDURES

301.1 Completing Inpatient Hospital Claim (Form MC-1)

Use a typewriter or legible printing for all entries on the form.

The following items are to be completed at the time of admission:

Item 1: Patient's Name-- Enter the patient's last name, and first name, as shown on the validation form.

Item 2: Case Name--Enter the name as it appears on the validation form.

Item 3: Sex--"X" in the appropriate block.

Item 4: Birth Date--Enter the patient's birth date by month, day and year. If the date of birth is unknown, transmit the claim form without the date of birth. If only the year of birth is known, show the year. While the date of birth is useful as identification and should be shown when available, a claim will be processed without it.

Item 5: Enter Admission Date.

Item 6-9: Leave blank.

Item 10: Enter Attending Physician's Name.

Item 11: Enter Medical Record Number.

Item 12: Health Services Program Case Number--Enter the covered person's program case number as shown on the identification card or validation form (See Section 101.)

Item 13: Patient Person Number--Enter the patient person number shown on the validation form. (See Section 101.)

NOTE: In maternity cases, when the child remains in the hospital after the mother is discharged, the hospital must contact the County Welfare Board in order to obtain the child's person number.

Item 14: Enter Provider Name and Address--Abbreviations may be used. This information may be preprinted.

Item 15: Enter Provider Number--This information may be preprinted.

Item 16: Patient's Address and Phone Number --Complete with all available patient information.

ADMISSION AND BILLING PROCEDURES

Item 17: Patient's Certification, Authorization to Release Information and Payment Request--Have the patient or his authorized representative read and sign the statement on the form. If the hospital obtains the signature on its own admission record form, check the block marked "Contained in Provider's Record." The signature on form MC-1 need be legible only on the original. If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf. The statement should be read to a patient who signs by mark, and witnessed by a person who knows the patient. Enter the name and address of the witness. In certain situations, a hospital representative may sign on behalf of the patient. If the patient is a minor, a parent or guardian should sign and indicate relationship.

Items 18-21: Leave blank.

Item 22: Admitting Diagnosis--Enter the admitting diagnoses as furnished by the physician. List the primary condition first.

NOTE: This Item must be completed in all instances.

301.2 Disposition of Form MC-1-C

The bottom copy of the Claim Form, County Copy (MC-1-C) must be submitted to the Local Medical Assistance Unit within 48 hours after admission. It is not to be sent to the contractor. The two top copies are retained by the hospital for billing purposes. (See Exhibits.)

302. BILLING PROCEDURES FOR INPATIENT SERVICES--GENERAL

Form MC-1 (1-70)--Inpatient Hospital Claim is used to bill for inpatient services in a participating hospital and for emergency inpatient services in a nonparticipating hospital.

ADMISSION AND BILLING PROCEDURES

302.1 Inpatient Admission After Outpatient Services

Sometimes a patient is admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient before midnight of the day outpatient services were rendered, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day on inpatient hospital services.

302.2 Leave of Absence

It is not necessary to submit a new admission and billing each time the patient has a leave of absence. Instead, the hospital may bill for days, excluding leave of absence. (See Section 303.)

302.3 Medicare/Medicaid Coverage

When the patient is covered under both programs, only a Medicare form (SSA 1453) should be completed, with Item 14 showing the Health Services Program case and person number on that Medicare form.

Where benefits have been exhausted under Medicare, the charges to be billed to the program must be itemized for the non-covered period and the case and person number must be shown on the Medicare form.

303. COMPLETION OF BILLING ITEMS ON THE FORM MC-1 (Exhibit I)

Items 6-7: From And Thru Dates--Enter 6 digit "From" and "Thru" dates for period covered by the bill.

In interim billing situations, the "Thru" date will be the last day billed. On the final bill submitted, the "Thru" entry will show the date of discharge or death.

Item 8: Enter number of Days involved in "From-Thru" dates.

NOTE: Days should not include

- a. Day of discharge or death.
- b. Days for which no payment can be made because patient was on a leave of absence.

If interim bill situation, include last day being billed. If final bill, do not include day of discharge or death.

ADMISSION AND BILLING PROCEDURES

Example:

<u>Period Billed</u>	<u>No. of Days</u>
1-1-70 thru 1-15-70 (Bill #1)	15
1-16-70 thru 1-19-70 (Bill #2)	4
1-20-70 thru 1-22-70 (Discharged)	2

Item 9: Leave Days--Show number of leave days. (See Section 302.2.)

Item 18: Statement of Charges

Show all charges for the period covered by the current billing for each of the departments. Where your hospital has more departments than shown on the form, utilize Items 26, 27 and 28.

Accommodations--See Section 201.1 for an explanation of the rules on other than semiprivate accommodations.

Accommodation days should not include the day of discharge, even where the discharge was late. However, where the hospital normally makes an extra charge for a late discharge, it should enter the extra charge under "Covered Charges." Where this charge was made because the patient remained in the hospital after checkout time for his own convenience, the charge should be entered under "Noncovered Charges." However, where the patient's stay beyond the checkout hour is occasioned by his medical condition, e.g., a bedridden patient awaiting transfer to his home or to an extended care facility, the services furnished by the hospital are entered under "Covered Charges."

Where the patient is discharged on his first day of entitlement, it is permissible to submit a billing form with no accommodation charge, but with ancillary charges shown on Lines 06 through 28. Ancillary charges for day of discharge, death, or the day on which a leave of absence begins, should be shown in the proper department.

Where more than one rate has been used for a given type of accommodation, one of the unused accommodation lines may be relettered and used to show the entry.

NOTE: In a maternity case, during the joint eligible stay, bill the accommodations for the mother on the appropriate accommodation line, and bill the nursery charge on Line 06. If the child continues to be hospitalized after the mother has been discharged, the nursery charges should be billed on a separate claim form.

ADMISSION AND BILLING PROCEDURES

All-Inclusive Rate Hospitals--For hospitals using all-inclusive rates, the line for the accommodation actually furnished is to be completed. The number of days, all inclusive rate, covered charges, and non-covered charges must be entered on the bill.

One Bed--Where a patient needed a private room for medical reasons, complete and attach one copy of form MC-5 to explain the medical necessity. (See Section 305.) Enter the number of days, the customary charge for a one-bed room and enter the total charge in the "Covered Charges" column. There is to be no entry in the "Non-covered Charges" column.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the cost of semiprivate accommodations. (The completion of Form MC-5, Explanation of Accommodation Furnished, is not necessary in this case.) In the Noncovered Charges column, show the difference between the private room charges and the most prevalent semiprivate room charges at the time of admission.

2-3-4 Bed--If the patient occupies semiprivate accommodations (2, 3, or 4-bed room) show the number of days and the actual daily rate for the accommodations and enter total under "Covered Charges."

Ward (5 or More Beds)--Under the Health Services Program, payment is ordinarily made for semiprivate accommodations (2, 3, 4-bed room). If the patient is assigned to a room with 5 or more beds, the hospital should complete Form MC-5, Explanation of Accommodations Furnished, explaining the reasons for this accommodation. A copy of the form should be attached to the billing form, and submitted to the contractor. (See Section 306.)

Coronary/Intensive Care and Self Care

Show the number of days the patient was in the coronary/intensive care and/or self care unit, number of days, applicable rate and enter total under "Covered Charges."

Line 05: Enter total "Covered" and "Noncovered" charges for accommodations in "Subtotal" line.

Lines 06-28: General

Show all charges for the period covered by the current billing for each of the departments. NOTE: Line 07 includes recovery room and Line 22 includes intravenous solution.

HOSPITAL ADMISSION AND BILLING PROCEDURES

Line 98: Enter total of covered and noncovered charges.

Item 19: Other Coverage--Remaining Charges

If patient has Medicare and Medicaid coverage, see Section 302.3. If patient does not have Medicare coverage, enter charges not covered by other insurance on Line 32 of Item 19. Appropriate information should be entered in Item 25.

NOTE: Item 19 is reserved solely for other insurance coverage.
Items 18 and 19 cannot be completed on the same claim form.

Item 20: Patient Status--Check Appropriate Block.

If discharged also enter date in Item 21.

If transferred to another medical facility, i.e., skilled nursing home, hospital, extended care facility, etc., the hospital should submit a discharge bill at this point and show the date the transfer occurred in Item 21. The hospital should also show under "Remarks" the name and address of the institution to which the patient was transferred.

If deceased enter date of death in Item 21.

If still patient when bill is submitted, check still patient block.

Item 21: Discharge Date--Enter date as noted in Item 20.

Item 22: Admitting Diagnosis--(See Section 301.2)

Item 23: Discharge or Current Diagnoses--Enter all the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record which relate to the condition requiring the current hospitalization. The primary diagnosis shown is the illness or condition which was the primary reason for the patient's hospitalization. Other diagnoses should be shown under secondary. The diagnoses should be shown in accordance with recognized nomenclature, e.g., "International Classification of Diseases Adapted," "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

Item 24: Surgical Procedure--Surgical procedure should be specified in detail using recognized nomenclature such as that in "Current Medical Terminology," "Current Procedural Terminology," "Standard Nomenclature of Diseases and Operations," etc. For the purpose of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulations.

HOSPITAL ADMISSION AND BILLING PROCEDURES

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 25: Employment Related--If the condition is considered to be employment related, the admitting diagnosis should always be shown along with the name and address of the employer. No program payments shall be made for a patient covered by Workmen's Compensation. (Any amounts not covered by Workmen's Compensation should be entered in Item 19, line 32 with an appropriate explanation in the Remarks section.)

Item 26: Other Insurance or Liability Coverage--Applies to coverage other than Medicare or Workmen's Compensation. (See Section 110.)

Item 27: Provider Certification and Signature--When a certification or recertification is required, a hospital representative should make sure that the physician's certification and recertifications are in the hospital records. In all cases the claim form should be dated before it is submitted to the contractor. The date forwarded should be the date the bill is actually mailed to the contractor and should not be before the "Thru" date in Item 7. A stamped signature is acceptable.

REMARKS--This block will be used by the hospital and/or contractor.

Item 28-37: For Contractor's use only.

304. Disposition of Forms MC-1, Reports and Request to Local Medical Assistance Units

304.1 Form MC-1

- a. The original copy (MC-1-A, Contractor's copy) must be forwarded to the hospital's contractor for processing.
- b. The second copy (MC-1-B, Provider's copy) is to be retained by the hospital.
- c. The third copy (MC-1-C, Notice of Admission) must be mailed to the Local Medical Assistance Unit within two (2) working days after admission.

HOSPITAL ADMISSION AND BILLING PROCEDURES

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 25: Employment Related--If the condition is considered to be employment related, the admitting diagnosis should always be shown along with the name and address of the employer. No program payments shall be made for a patient covered by Workmen's Compensation. (Any amounts not covered by Workmen's Compensation should be entered in Item 19, line 32 with an appropriate explanation in the Remarks section.) Also check the appropriate box to indicate whether or not the services rendered were as a result of a Motor Vehicle accident.

Item 26: Other Insurance or Liability Coverage--Check type of other insurance coverage, other than Medicare or Workmen's Compensation, (See Section 110) and insert the other carrier's name and policy number.

Item 27: Provider Certification and Signature--When a certification or recertification is required, a hospital representative should make sure that the physician's certification and recertification are in the hospital records. In all cases the claim form should be dated before it is submitted to the contractor. The date forwarded should be the date the bill is actually mailed to the contractor and should not be before the "Thru" date in Item 7. A stamped signature is acceptable.

REMARKS--This block will be used by the hospital and/or contractor.

Item 28-37: For Contractor's use only.

304. Disposition of Forms MC-1, Reports and Request to Local Medical Assistance Units

304.1: Form MC-1

- a. The original copy (MC-1-A, Contractor's copy) must be forwarded to the hospital's contractor-for processing.
- b. The second copy (MC-1-B, Provider's copy) is to be retained by the hospital.
- c. The third copy (MC-1-C, Notice of Admission) must be mailed to the Local Medical Assistance Unit within two (2) working days after admission.

HOSPITAL ADMISSION AND BILLING PROCEDURES

304.2 Other Reports and Requests Required by Local Medical Assistance Units.

The following is a list of Local Medical Assistance Units, their identification number and their addresses. It should be noted that the identification number comprises the first two positions of the Health Services Program Identification number and indicates which Local Medical Assistance Unit has jurisdiction in submission of requests for authorization and other reports.

N.B. Inquiries concerning eligibility and applications for eligibility are to be sent to the County Welfare Board of patient's residence.

304.3 Directory of Local Medical Assistance Units.

<u>COUNTY</u> <u>'CODE</u>	<u>COUNTY</u>	<u>STREET</u> <u>ADDRESS</u>	<u>MUNICIPALITY</u>	<u>ZIP</u> <u>CODE</u>	<u>P.O.</u> <u>BOX</u>	<u>TELEPHONE</u>
01	Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1970	609-344-2861
05	Cape May	" " "	" "	"	"	" " "
02	Bergen	50 Main Street	Hackensack	07601		201-488-5667
03	Burlington	Chesley & Alloway Bldg. Rt.38&Eayrestown Rd.	Mt. Holly	08060		609-261-0448
04	Camden	530 Cooper St	Camden	08101	19	609-365-3926
06	Cumberland	7 E. Broad St	Bridgeton	08302	440	609-451-6550
07	Essex #1	796 Broad St	Newark	07101	1576	201-648-2470
07	Essex #2	505 South 15th St	Newark	07101		201-648-3700
08	Gloucester	42 Delaware Ave.	Woodbury	08096	1900	609-845-7185
17	Salem	" " "	"	"	"	" " "
09	Hudson	100 Newkirk Street	Jersey City	07306		201-792-6390
10	Hunterdon	6 Court Street	Flemington	08822		201-782-1130
18	Somerset	" " "	"	"		" " "
21	Warren	" " "	"	"		" " "
11	Mercer	324 E.State Street	Trenton	08625	2465	609-292-7315
12	Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-246-0653
13	Monmouth	320 Broad Street	Red Bank	07701		201-842-6440
14	Morris	4 Court Street	Morristown	07960		201-267-1700
19	Sussex	" " "	"	"		" " "
15	Ocean	1851 Hooper Avenue	Toms River	08753		201-255-6226
16	Passaic	152 Market Street	Paterson	07509	2863	201-523-2800
20	Union	7 Bridge Street	Elizabeth	07201		201-355-8860

305. EXPLANATION OF ACCOMODATION FURNISHED (Form MC-5) (EXHIBIT II)

Form MC-5, Explanation of Accommodation Furnished is used by the hospital to explain an accommodation other than a two-, three-, or four bed room

HOSPITAL ADMISSION AND BILLING PROCEDURES

The cost of a one-bed accommodation is covered by the Health Services Program if it is medically necessary. The medical necessity for a private accommodation should be described on the MC-5 from the physician's order and the reason as given by him in the hospital's medical record. It is not necessary to attach a special statement from the doctor for this purpose.

Where the patient was furnished a one-bed accommodation for reasons other than medical necessity, it is not necessary to complete a form MC-5.

Where the patient requested a five-bed accommodation, the hospital should complete a single copy of the MC-5 for attachment to the bill and have the patient sign the form in the Patient's Signature block under Item 19.

Where the patient was assigned a five-bed accommodation not at his request, the hospital should complete the MC-5 for attachment to the bill showing the reason for such assignment.

306. COMPLETING ITEMS ON THE FORM MC-5

Items 1-16: Should be entered exactly as they appear on inpatient hospital claim form MC-1.

Item 17: Type of Accommodation Furnished

Enter the accommodation furnished and the applicable daily rate. Item A, the most prevalent semiprivate rate, should be completed in all cases. This is the semiprivate rate most frequently used in the hospital. (A hospital with private rooms only will use the equivalent semiprivate rate determined by the contractor.)

To determine the most prevalent charge for semiprivate accommodations, consider the following features:

1. Type of Accommodation.
2. Total rooms of each type for each different room rate.
3. Total beds found in each type for each room rate.
4. Rate you charge daily for the type of room.

Your most prevalent charge for semiprivate accommodations is that single rate you charge for the largest entry appearing under your "Total Beds" column.

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Example:

(1) Type of accommodation	(2) Total rooms of this type	(3) Total beds col. (1) X col. (2)	(4) Rate per day
2 beds	10	20	\$30
2 beds	8	16	35
3 beds	2	6	20
4 beds	1	4	15

NOTE: \$30 is the most prevalent semiprivate charge.

Item 18: Reason for Assignment to Accommodation Mentioned

A. Patient's Request--Where a five or more bed accommodation was furnished at a patient's request, the patient should sign the MC-5 in Item 19. Enter the date of signing in Item 20.

Item 19: Patient's Signature--As noted above.

Item 20: Date of Signature.

Item 21: Medical Necessity--Describe the reason for assignment to a one-bed room from the physician's order shown in the hospital records.

Item 22: Other Reasons--Where the hospital believes that an assignment to a five or more bed accommodation is justifiable for some other reason, it should describe the reason in this block.

Item 23: Signature of Hospital Representative--The responsible hospital representative should sign and date the form in Item 24. A stamped signature is acceptable.

Item 24: Date of Signature.

Item 25-28: For Contractor's use only.

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307. INPATIENT RECERTIFICATION

307.1 Recertification

Whenever the span of inpatient days allowed under AID (Approval by Individual Diagnosis--See Section 203.3) will be exceeded, the attending physician is required to certify concerning the necessity of continued hospitalization beyond the AID days.

307.2 Promptness of Recertification

The regulations of the New Jersey Health Services Program require the recertification of the need for continued hospital stay of the patient. The attending physician is required to complete the recertification on or before the expiration of the AID days. Program payment will not be made unless this requirement is met.

307.3 Inpatient Recertification (Form MC-2) (Exhibit III)

Form MC-2 Inpatient Recertification is to be used by the attending physician whenever AID days are exceeded as noted above. The form is to be completed in quadruplicate, and signed by the attending physician (See Section 309.).

308. COMPLETING ITEMS ON FORM MC-2

Inpatient Recertification--Items 1-16--Information can be obtained from the claim Form MC-1 and listed exactly as it appears on that form.

Item 17: AID - Complete with the number of days allowed for the previous diagnosis according to the AID Manual, Second Revision, and enter the calendar date on which this AID allowance ends.

Attending physician is required to answer the Items listed below:

Item 1: Current Diagnosis--The Current Diagnosis must be specified in all instances.

Item 2: Reason for Continued Hospitalization--State why confinement will exceed number of days allowed under AID.

Item 3: Approximate Additional Necessary Length of stay if still hospitalized. The additional stay required should be specified in days.

Item 4: Post-Hospital Care--Check the applicable box.

Date: The month, day and year on which the recertification was completed and signed should be indicated. (This date should be no later than the date shown in Item 17 above).

The attending physician's signature must appear on all copies of the form.

ADMISSION AND BILLING PROCEDURES

309. DISPOSITION OF COPIES OF COMPLETED MC-2 (A.I.D. Hospital)
- A. The original (MC-2-A Contractor's Copy) must be forwarded to the hospital's contractor with Form MC-1 for processing.
 - B. The second copy (MC-2-B County Copy) must be mailed to the Local County Medical Assistance Unit.
 - C. The third copy (MC-2-C Provider Copy) will be retained by the hospital.
 - D. The fourth copy (MC-2-D Utilization Committee Copy) will be forwarded to the provider's Utilization Review Committee for review.

309.1 Disposition of Copies of Completed Forms MC-2 When Used for Prior Authorization Request

Hospitals which do not have the AID Program must utilize the MC-2 (1-70) as a request for Prior Authorization for inpatient services beyond the 21st day. The completed original, second, and third copies are forwarded to the Local Medical Assistance Unit for review. The fourth copy will be forwarded to the provider's Utilization Review Committee. If the Local Medical Assistance Unit has authorized the additional days, it will be indicated by signature on the original and third copy, specifying the additional days allowed and the expiration date. The hospital will forward the original copy (MC-2A) to the appropriate Contractor together with the claim for payment.

310. BILLING PROCEDURES FOR OUTPATINET SERVICES--GENERAL

(Not Available for Special Hospital in Classification C)

Form MC-4 Outpatient Hospital Billing--will be used by a hospital to report outpatient services.

Under the New Jersey Health Services Program, the Hospital must submit this form on a monthly billing cycle. However, separate claim forms will be required for services rendered in different calendar quarters.

A. PROCEDURE FOR BILLING FOR DENTAL SERVICES

After completion of treatment, either authorized or routine, the Dental Form (MC-10), with descriptions and dates of services rendered, utilizing proper procedure code numbers, is attached to the Hospital Outpatient Form (MC-4) which is used to make the charge for the dental clinic visit. These forms are then submitted to the appropriate fiscal agent for the hospital.

B. PROCEDURE FOR BILLING FOR MEDICARE/MEDICAID PATIENT

When the patient is covered under both programs only a Medicare Form (SSA-1483) should be completed, with Item 11 showing the Health Services Program Case and Person Number on that Medicare form.

When prior authorization is required for program purposes it must be obtained and submitted with the Medicare billing form.

311. COMPLETION OF ITEMS FORM MC-4 (Exhibit IV)

Use a typewriter or legible printing for all entries on the form.

Item 1: Patient's Name--Enter the patient's last name, and first name, as shown on the validation form.

ADMISSION AND BILLING PROCEDURES

- Item 2: Case Name--Enter the name as it appears on the validation form.
- Item 3: Sex--Enter "X" in the appropriate block.
- Item 4: Birth Date--Enter the patient's birth date by month, day and year. If the date of birth is unknown, transmit the claim form without the date of birth. If only the year of birth is known, show the year. While the date of birth is useful as identification and should be shown when available, a claim will be processed without it.
- Item 5: Leave blank.
- Item 6-7: Claim From and Thru Dates--Enter the dates of the first and last service for period covered by the claim form.
- Item 8: Visits--Enter the number of visits for the period covered by the claim form.
- Item 9: Leave blank.
- Item 10: Attending Physician--Enter attending physician's name.
- Item 11: Enter Medical Record Number.
- Item 12: Health Service Program Case Number--Enter the patient's program case number as shown on the identification card or validation form (See Section 101.)
- Item 13: Patient Person Number--Enter the patient person number shown on the validation form. (See Section 101.)
- Item 14: Provider Name and Address--Enter provider name and address. Abbreviations may be used. This information may be preprinted on all copies of the hospital's supply of these forms.
- Item 15: Provider Number--Enter the provider number. This information may be preprinted.
- [Item 16: Enter the patient's Address and Telephone Number when available.
- Item 17: Patient's Certification, Authorization to Release Information and Payment Request--Have the patient or his authorized representative read and sign the statement on the form. If the hospital obtains the signature on its own admission record form, check the block marked "Contained in Provider's Record." The signature on form MC-4 need be legible only on the original.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf.

ADMISSION AND BILLING PROCEDURES

The statement should be read to a patient who signs by mark, and witnessed by a person who knows the patient. Enter the name and address of the witness. In certain situations, a hospital representative may sign on behalf of the patient. If the patient is a minor, a parent or guardian should sign and indicate relationship.

Item 18: Type of Clinic/Dates Visited--Check the appropriate box concerning whether a Plan of Treatment, established by the physician, is being retained in your hospital records. Further indicate the date established if applicable. Complete the remaining portion by entering the type of clinic and the date of each visit.

Item 19: Statement of Charges--Enter the charges for the period covered by the claim. Lines 26, 27 and 28 should be used to list additional services. Show total charges on Line 98.

Item 20: Other Coverage--Remaining Charges

If patient is also covered under Medicare, see Section 310. If patient does not have Medicare coverage, enter charges not covered by other insurance in Item 20, Line 32. Appropriate information should be entered in Item 25.

NOTE: Item 20 is reserved solely for other insurance coverage
Item 19 and 20 cannot be completed on the same claim form.

Item 21: Patient Status--Check Appropriate Block.

Item 22: Nature of Service Rendered--List here, from the patient's hospital record, the nature of the illness or injury for which services were given. Acceptable medical terminology should be used, such as International Classification of Diseases Adapted, Current Medical Terminology, etc. If the nature of the illness or injury is not known, enter "not known".

Item 23: Surgical Procedures--Surgical procedures should be specified in detail using recognized nomenclature such as that used in "Current Medical Terminology," "Current Procedural Terminology," "Standard Nomenclature of Disease and Operations," etc. For the purpose of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulations.

Enter the name of the procedure, if any, which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order.

Item 24: Employment Related--If the condition is considered to be employment related, the diagnosis should always be shown along with the name and address of the employer. No program payments shall be made for a patient covered by Workmen's Compensation. (Any amounts not covered by Workmen's Compensation should be entered in Item 20 Line 32 with an appropriate explanation in the Remarks section.) Also indicate whether the services were rendered as the result of a Motor Vehicle accident by checking the appropriate box.

HOSPITAL ADMISSION AND BILLING PROCEDURES

Item 25: Other Insurance or Liability Coverage--Check the type of other insurance coverage (other than Medicare or Workmen's Compensation - See Section 110.) and insert the other carrier's name and policy number.

Item 26: Provider Certification and Signature--The date forwarded should be the date the bill is actually mailed to the contractor. The date used should not be before the "Thru" date in the "Statement Covers Period" Item 7. A stamped signature is acceptable.

REMARKS--This block will be used by the hospital and/or contractor.

Items 28-37: For Contractor's use only.

312. DISPOSITION OF COPIES OF COMPLETED FORM MC-4

- A. The original copy (MC-4-A Contractor's Copy) will be forwarded to the hospital's contractor for processing.
- B. The second copy (MC-4-B Provider Copy) will be retained by the hospital.

313. COMPLETING ITEMS ON FORM MC-7

Form MC-7 Hospital Pharmacy Report must be completed when take home drugs are dispensed by Outpatient Hospital facilities.

Patient's Name--Enter the patient's last name and first name, as shown on the validation form.

Health Services Program Case Number--Enter the patient's program case number as shown on the identification card or validation form. (See Section 101.)

Patient Person Number--Enter the patient person number shown on the validation form. (See Section 101.)

Drug Supplied--Enter generic name of drug.

Provider Number--Enter the provider number.

Manufacturer--Enter name of drug manufacturer.

Cost--Enter actual invoice cost.

Quantity Dispensed--Enter quantity dispensed in metric system only.

Day's Supply--Enter number of days.

Dosage Form--Enter drug directions.

HOSPITAL ADMISSION AND BILLING PROCEDURES

Item 25: Other Insurance or Liability Coverage--Applies to coverage other than Medicare or Workmen's Compensation. (See Section 110.)

Item 26: Provider Certification and Signature--The date forwarded should be the date the bill is actually mailed to the contractor. The date used should not be before the "Thru" date in the "Statement Covers Period" Item 7. A stamped signature is acceptable.

Remarks--This block will be used by the hospital and/or contractor.

Items 28-37: For Contractor's use only.

312. DISPOSITION OF COPIES OF COMPLETED FORM MC-4

- A. The original copy (MC-4-A Contractor's Copy) will be forwarded to the hospital's contractor for processing.
- B. The second copy (MC-4-B Provider Copy) will be retained by the hospital.

313. COMPLETING ITEMS ON FORM MC-7

Form MC-7 Hospital Pharmacy Report must be completed when take-home drugs are dispensed by Outpatient Hospital facilities.

Patient's Name - Enter the patient's last name and first name, as shown on the validation form.

Health Services Program Case Number - Enter the patient's program case number as shown on the identification card or validation form. (See Section 101.)

Patient Person Number - Enter the patient person number shown on the validation form. (See Section 101.)

Drug Supplied - Enter generic name of drug.

Provider Number - Enter the provider number.

Manufacturer - Enter name of drug manufacturer.

Cost - Enter actual invoice cost.

Quantity Dispensed - Enter quantity dispensed in metric system only.

Day's Supply - Enter number of days.

Dosage Form - Enter drug directions.

HOSPITAL ADMISSION AND BILLING PROCEDURES

Strength - Enter strength of drug.

Rx Number - Enter Rx number.

Original Rx or Refill -- Check one.

Date Dispensed - Enter current date.

314. DISPOSITION OF COMPLETED FORM MC-7

- a. Attach to Outpatient Claim form MC-4A.
- b. Forward with MC-4A to the hospital's contractor for processing.

315. PROCEDURES FOR SUBMITTING CORRECTED INPATIENT AND OUTPATIENT BILLS

The hospital may find that a bill already submitted is incorrect. It is not necessary to submit a corrected Form MC-1 or Form MC-4 unless total charges change by more than \$10.00.

To correct a previously submitted bill, the hospital should reproduce a legible copy of the submitted bill. The necessary corrections should be made in red in the appropriate item. The corrected bill should be marked "Debit--Adjust" in the upper right hand corner, and mailed to the Contractor.

To cancel all the charges on a previously submitted bill, reproduce a legible copy and mark it "Cancel Only" in the upper right margin. An explanation for the correction should be given on the reverse side of the bill, and mailed to the Contractor.

316. EXHIBITS

- I. MC-1-A Inpatient Hospital Claim Form
- II. MC-5 Explanation of Accommodation Furnished Form
- III. MC-2-A Inpatient Recertification Form
- IV. MC-4-A Outpatient Hospital Claim Form
- V. MC-1-C Hospital Admission - Notification Form
- VI. MC-7 Hospital Pharmacy Rx Report



INPATIENT HOSPITAL CLAIM

1. Patient's Last Name		First Name		2. Case Last Name		First Name		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		4. Birthdate Mo. / Day / Yr.	
5. Admission Date Mo. / Day / Yr.		6. Claim From-Date Mo. / Day / Yr.		7. Claim Thru-Date Mo. / Day / Yr.		8. Days		9. Leave Days		10. Attending Physician's Name (Please Print) Last First M.I.	
12. Health Services Program Case No.						13. Patient Person No.		14. Provider Name and Address			15. Provider Number
16. Patient's Address						Telephone Number					

17. PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

Contained in provider's record Signature (Patient or authorized representative) _____ Date _____

18. STATEMENT OF CHARGES			
ACCOMMODATION	DAYS	RATE	COVERED CHARGES
1 Bed			
2, 3, 4 Bed			
Ward			
Coronary/Intensive Care			
Self Care			
SUBTOTAL ACCOM. CHARGES		05	
NURSERY	DAYS	06	
OPERATING ROOM		07	
DELIVERY ROOM		08	
PHYSICAL THERAPY		10	
SPEECH THERAPY		11	
OCCUPATIONAL THERAPY		12	
ADIATION THERAPY		13	
INHALATION/OXYGEN THERAPY		14	
LABORATORY		15	
X-RAYS		16	
EKG'S		17	
EEG'S		18	
ADMIN. OF ANESTHESIA		19	
ADMIN. OF BLOOD		20	
BLOOD		21	
PHARMACY		22	
SUPPLIES-Medical/Surgical		23	
AMBULANCE (Hospital Owned)		24	
OTHER (Describe)		26	
		27	
		28	
TOTAL		98	

20. Patient Status <input type="checkbox"/> Still Patient <input type="checkbox"/> Deceased <input type="checkbox"/> Discharged <input type="checkbox"/> TRANSFER TO OTHER INPATIENT FACILITY		21. Discharge Date Mo. / Day / Year	
22. Admitting Diagnosis			
23. Discharge or current diagnoses Primary _____ Secondary _____			
24. Surgical Procedures (Show date of each) Primary _____ Secondary _____			
25. Claim related to employment? _____ If yes, give name of employer. Auto accident Yes <input type="checkbox"/> No <input type="checkbox"/>			
26. Other Insurance or Liability Coverage <input type="checkbox"/> (Check appropriate No Fault Auto Coverage <input type="checkbox"/> Box) Policy Number _____ Name of Carrier _____			
27. PROVIDER CERTIFICATION: "I certify that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. I understand that fraud or concealment will be punishable under applicable Federal or State law, or both."			
Provider Representative Signature _____		Date Sent _____	
REMARKS:			

DO NOT USE AREA BELOW

28. ACCOMMODATION CODE 3 - PRIVATE 5 - COMBINATION 4 - SEMI-PR. 6 - WARD 7 - NURSERY 8 - SELF CARE 9 - INTER. CARE		29. PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		PRIMARY SURG. PROCEDURE		SECONDARY SURG. PROCEDURE		30. ADJUDICATOR CODE		31. DECLINE CODE	
32. ELAPSED DAYS TO SURGERY		33. OTHER COVERAGE CODE 0 - NONE 1 - MEDICARE A 2 - MEDICARE B 3 - OTHER INSURANCE 4 - LIABILITY 5 - OTHER		34. PATIENT STATUS <input type="checkbox"/> 1 - STILL PATIENT <input type="checkbox"/> 2 - DISCHARGED <input type="checkbox"/> 3 - DECEASED <input type="checkbox"/> 4 - TRANSFER TO OTHER INPATIENT FACILITY		35. PAYMENT		36. PROCESS CODE		37. TRAN. CODE			

PLEASE TYPE OR PRINT



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

INPATIENT HOSPITAL CLAIM

Patient's Last Name		First Name		Sex 1. Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate 3. Mo. / Day / Yr.		4.
Admission Date 5. Mo. / Day / Yr.	Claim From-Date 6. Mo. / Day / Yr.	Claim Thru-Date 7. Mo. / Day / Yr.	Days 8.	Leave Days 9.	Attending Physician's Name (Please Print) 10. Last First M.I.		Medical Record No. 11.
Health Services Program Case No. 12.				Patient Person No. 13.	Provider Name and Address 14.		Provider Number 15.
Case Last Name 16.		First Name					

17. PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

Contained in provider's record Signature (Patient or authorized representative) _____ Date _____

18. STATEMENT OF CHARGES

ACCOMMODATION	DAYS	RATE	COVERED CHARGES	NON-COVERED CHARGES
1 Bed				
2, 3, 4 Bed				
Ward				
Coronary/Intensive Care				
Self Care				
SUBTOTAL ACCOM. CHARGES		05		
NURSERY		06		
OPERATING ROOM		07		
DELIVERY ROOM		08		
PHYSICAL THERAPY		10		
SPEECH THERAPY		11		
OCCUPATIONAL THERAPY		12		
RADIATION THERAPY		13		
INHALATION/OXYGEN THERAPY		14		
LABORATORY		15		
X-RAYS		16		
EKG'S		17		
EEG'S		18		
ADMIN. OF ANESTHESIA		19		
ADMIN. OF BLOOD		20		
BLOOD		21		
PHARMACY		22		
SUPPLIES-Medical/Surgical		23		
AMBULANCE (Hospital Owned)		24		
OTHER (Describe)		26		
		27		
		28		
TOTAL		98		

19. OTHER COVERAGE - REMAINING CHARGES

MEDICARE - DEDUCTIBLE	29		
MEDICARE - Co-Insurance	30		
MEDICARE - OTHER	31		
OTHER (Describe)	32		
TOTAL	99		

Patient Status
20. Still Patient Deceased Discharged Transfer to other inpatient facility

Discharge Date
21. Mo. / Day / Year

Admitting Diagnosis
22.

Discharge or current diagnoses
23.

Primary
Secondary

Surgical Procedures (Show date of each)
24. Primary
Secondary

Claim related to employment? _____ . If yes, give name of employer.
25.

Other insurance or liability coverage
26. Name _____ Policy Number _____

27. PROVIDER CERTIFICATION: I certify that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the provisions of Title VI of the Federal Civil Rights Act.

Provider Representative Signature _____ Date Sent _____

REMARKS:

DO NOT USE AREA BELOW

ACCOMMODATION CODE 28. PRIVATE 5 - COMBINATORIAL 2 - SEMI-PR. 3 - WARD 4 - NURSERY 5 - INTENSIVE CARE 6 - RTEN. CARE	29. PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	PRIMARY SURG. PROCEDURE	SECONDARY SURG. PROCEDURE	ADJUDICATOR CODE 30.	DECLINE CODE 31.
ELAPSED DAYS TO SURGERY 32.	OTHER COVERAGE CODE 33. 0-NONE 1-MEDICARE A 2-MEDICARE B 3-OTHER INSURANCE 4-LIABILITY 5-OTHER	PATIENT STATUS 34. 1-STILL PATIENT 2-DISCHARGED 3-DECEASED 4-TRANSFER TO OTHER INPATIENT FACILITY	PAYMENT 35.	PROCESS CODE 36.	TRAN. CODE 37.	

MC-1A (1-70)

CONTRACTOR'S COPY

COMB 32899A ED 1-70
Printed in U.S.A.

MC-1B (1-70)

PROVIDER COPY

COMB 32899B ED 1-70
Printed in U.S.A.

MC-1C (1-70)

COUNTY COPY

COMB 32899C ED 1-70
Printed in U.S.A.

EXHIBIT II



STATE OF NEW JERSEY
 Department of Institutions and Agencies
 Division of Medical Assistance and Health Services

EXPLANATION OF ACCOMMODATION FURNISHED

1. Patient's Last Name		First Name		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Birthdate Mo. / Day / Yr.		4. [Shaded]	
5. Admission Date Mo. / Day / Yr.		6. Claim From-Date Mo. / Day / Yr.		7. Claim Thru-Date Mo. / Day / Yr.		8. [Shaded]		9. [Shaded]	
10. [Shaded]		11. Medical Record No.		12. Health Services Program Case No.		13. Patient Person No.		14. Provider Name and Address	
15. Provider Number		16. Case Last Name		First Name		17. TYPE OF ACCOMMODATION FURNISHED			

17A. MOST PREVALENT SEMI-PRIVATE RATE						\$
17B. 1-BED			17C. 5-OR-MORE-BED			
FROM (Date)	TO (Date)	RATE	FROM (Date)	TO (Date)	RATE	

18. REASON FOR ASSIGNMENT TO ACCOMMODATION MENTIONED

18A. PATIENT'S REQUEST - The 5-or-more-bed accommodation shown above was furnished because I requested it.

19. PATIENT'S SIGNATURE

20. DATE

21. MEDICAL NECESSITY (Describe)

22. OTHER REASON (Specify)

23. SIGNATURE OF HOSPITAL REPRESENTATIVE

24. DATE

25. FOR CONTRACTOR'S USE

26. Where Contractor determines that assignment to 5-or-more-bed room was not at patient's request, or was not consistent with the purposes of the Act, give difference between total of charges for accommodation at the most prevalent 2-3-4 bed room rate and charges for a 5-or-more-bed room for all covered days included on bill for services attached.

27. CONTRACTOR'S APPROVAL

28. DATE



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

EXHIBIT III

INPATIENT CERTIFICATION

1. Patient's Last Name		First Name		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Birthdate Mo. / Day / Yr.		4.	
5. Admission Date Mo. / Day / Yr.		6. Claim From-Date Mo. / Day / Yr.		7. Claim Thru-Date Mo. / Day / Yr.		8. Days		9. Leave Days	
10. Attending Physician's Name (Please Print) Last First M. I.									
11. Medical Record No.									
12. Health Services Program Case No.									
13. Patient Person No.									
14. Provider Name and Address									
15. Provider Number									
16. Case Last Name					First Name				
17. For the previous diagnosis AID allows _____ days. The expiration date is _____ Mo. Day Yr.									

ATTENDING PHYSICIAN'S STATEMENT REGARDING CONTINUED HOSPITALIZATION

NOTE TO DOCTOR: Please answer items listed below for the above named patient if (s)he will be hospitalized in excess of the number of days allowed according to the Approval by Individual Diagnosis (AID) Program. Before payment consideration can be made by the New Jersey Health Services Program, the regulation requires certification of patient's need for continued hospitalization prior to the expiration date shown in Item #17. The Program will consider subsequent approvals exceeding the initial AID days allowed in cases where long-term hospitalization is anticipated, if such approval is requested and an explanation (attached) at the time the certification is submitted.

1. Current Diagnosis (Please use accepted medical terminology).
2. My reason for continued hospitalization of this patient is:
3. I estimate the approximate inpatient hospitalization necessary, extending beyond the expiration date indicated in Item #17, is _____ days. A separate certification form (MC-2) should be completed each time the AID days allowed are expiring.
4. My plans for Post-Hospital Care for this patient are:

<input type="checkbox"/> Home	<input type="checkbox"/> Home Health Agency
<input type="checkbox"/> Office	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Extended Care Facility	_____

Attending Physician's Signature

Date Signed

Mo. Day Yr.

PLEASE TYPE OR PRINT



STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

OUTPATIENT HOSPITAL CLAIM

1. Patient's Last Name		First Name		Sex 2.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate 3.	4.
5.	6. Claim From-Date Mo. / Day / Yr.	7. Claim Thru-Date Mo. / Day / Yr.	8. Visits	9.	10. Attending Physician's Name (Please Print) Last First M.I.		11. Medical Record No.
12. Health Services Program Case No.			13. Patient Person No.		14. Provider Name and Address		15. Provider Number

16. Case Last Name: _____ First Name: _____

17. PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

18. TYPE OF CLINIC (Indicate Dates Visited)

Patient's Signature (Authorized Representative): _____ Date: _____

19. STATEMENT OF CHARGES

CLINIC VISIT	01		
EMERGENCY/OPERATING ROOM	09		
PHYSICAL THERAPY	10		
SPEECH THERAPY	11		
OCCUPATIONAL THERAPY	12		
RADIATION THERAPY	13		
INHALATION/OXYGEN THERAPY	14		
LABORATORY	15		
X-RAYS	16		
ADMIN. OF ANESTHESIA	19		
ADMIN. OF BLOOD	20		
BLOOD	21		
PHARMACY	22		
SUPPLIES - MEDICAL/SURGICAL	23		
OTHER (Describe)	26		
	27		
	28		
TOTAL	98		

20. OTHER COVERAGE - REMAINING CHARGES

MEDICARE - DEDUCTIBLE	29		
MEDICARE - CO-INSURANCE	30		
MEDICARE - OTHER	31		
OTHER (Describe)	32		
TOTAL	99		

21. Patient Status: Still Patient Discharged Deceased

22. Nature of Services Rendered

23. Surgical Procedures (Show date of each)
Primary: _____
Secondary: _____

24. Claim related to employment? _____ . If yes, give name of employer.

25. Other Insurance or Liability Coverage
Name: _____ Policy Number: _____

26. PROVIDER CERTIFICATION: I certify that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the provisions of Title VI of the Federal Civil Rights Act.

Provider Representative Signature: _____ Date Sent: _____

REMARKS:

DO NOT USE AREA BELOW

28. 1-EMERGENCY 2-PRIOR AUTH.	29. CLINIC TYPE	CLINIC TYPE	CLINIC TYPE	CLINIC TYPE	PRIMARY SURG. PROCEDURE	SECONDARY SURG. PROCEDURE	ADJUDICATOR CODE	DECLINE CODE
<input type="checkbox"/>								
32. <input type="checkbox"/>	33. OTHER COVERAGE CODE	34. PATIENT STATUS		35. PAYMENT	36. PROCESS CODE	37. TRAN. CODE		
	<input type="checkbox"/> 0-NONE <input type="checkbox"/> 1-MEDICARE A <input type="checkbox"/> 2-MEDICARE B <input type="checkbox"/> 3-OTHER INSURANCE <input type="checkbox"/> 4-LIABILITY <input type="checkbox"/> 5-OTHER	<input type="checkbox"/> 1-STILL PATIENT <input type="checkbox"/> 2-DISCHARGED <input type="checkbox"/> 3-DECEASED			<input type="checkbox"/>	<input type="checkbox"/>		

MC-4A (1-70) CONTRACTOR'S COPY COMB 32898A ED 1-70 Printed in U.S.A.

MC-4B (1-70) PROVIDER COPY COMB 32898B ED 1-70 Printed in U.S.A.



OUTPATIENT HOSPITAL CLAIM

1. Patient's Last Name		First Name		2. Case Last Name		First Name		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		4. Birthdate Mo. / Day / Yr.	
6. Claim From-Date Mo. / Day / Yr.		7. Claim Thru-Date Mo. / Day / Yr.		8. Visits		9. <input type="checkbox"/>		10. Attending Physician's Name (Please Print) Last First M.I.		11. Medical Record No.	
12. Health Services Program Case No.				13. Patient Person No.		14. Provider Name and Address				15. Provider Number	
16. Patient's Address				Telephone Number							

17. PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.

Contained in provider's record Signature (Patient or authorized representative) _____ Date _____

18. TYPE OF CLINIC (Indicate Dates Visited) Plan of treatment on file Yes No. If yes, date established _____ Mo. Day Yr.

19. STATEMENT OF CHARGES	
CLINIC VISIT	01
EMERGENCY/OPERATING ROOM	09
PHYSICAL THERAPY	10
SPEECH THERAPY	11
OCCUPATIONAL THERAPY	12
RADIATION THERAPY	13
INHALATION/OXYGEN THERAPY	14
LABORATORY	15
X-RAYS	16
ADMIN. OF ANESTHESIA	19
ADMIN. OF BLOOD	20
BLOOD	21
PHARMACY	22
SUPPLIES - MEDICAL/SURGICAL	23
OTHER (Describe)	26
	27
	28
TOTAL	98
20. OTHER COVERAGE - REMAINING CHARGES	
MEDICARE - DEDUCTIBLE	29
MEDICARE - CO-INSURANCE	30
MEDICARE - OTHER	31
OTHER (Describe)	32
TOTAL	99

21. Patient Status
 Still Patient Discharged Deceased

22. Nature of Services Rendered

23. Surgical Procedures (Show date of each)
Primary _____
Secondary _____

24. Claim related to employment? _____ If yes, give name of employer.
Auto accident Yes No.

25. Other Insurance or Liability Coverage (Check appropriate Box) Policy Number _____
No Fault Auto Coverage Name of Carrier _____

26. PROVIDER CERTIFICATION: "I certify that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. I understand that fraud or concealment will be punishable under applicable Federal or State law, or both."

Provider Representative Signature _____ Date Sent _____

REMARKS:

DO NOT USE AREA BELOW

28. 1 - EMERGENCY 2 - PRIOR AUTH.	29. CLINIC TYPE CLINIC TYPE CLINIC TYPE CLINIC TYPE	34. PATIENT STATUS <input type="checkbox"/> 1 - STILL PATIENT <input type="checkbox"/> 2 - DISCHARGED <input type="checkbox"/> 3 - DECEASED	35. PAYMENT	36. PROCESS CODE	37. TRAN. CODE	30. ADJUDICATOR CODE	31. DECLINE CODE

PLEASE TYPE OR PRINT



STATE OF NEW JERSEY
 Department of Institutions and Agencies
 Division of Medical Assistance and Health Services

HOSPITAL ADMISSION - NOTIFICATION FORM

Patient's Last Name 1.		First Name		Sex 2.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate 3.	Mo. / Day / Yr.		A.																						
Admission Date 5.	Claim From-Date 6.	Claim Thru-Date 7.	Days 8.	Leave Days 9.	Attending Physician's Name (Please Print) 10.			Medical Record No. 11.																							
Mo. / Day / Yr.		Mo. / Day / Yr.		Mo. / Day / Yr.		Last		First		M.I.																					
Health Services Program Case No. 12.				Patient Person No. 13.	Provider Name and Address 14.				Provider Number 15.																						
Case Last Name 16.		First Name																													
<p>NOTE: First two digits of Health Services Program Case Number indicate county designation.</p> <table border="0"> <tr> <td>01 - Atlantic</td> <td>04 - Camden</td> <td>07 - Essex</td> <td>10 - Hunterdon</td> <td>13 - Monmouth</td> <td>16 - Passaic</td> <td>19 - Sussex</td> </tr> <tr> <td>02 - Bergen</td> <td>05 - Cape May</td> <td>08 - Gloucester</td> <td>11 - Mercer</td> <td>14 - Morris</td> <td>17 - Salem</td> <td>20 - Union</td> </tr> <tr> <td>03 - Burlington</td> <td>06 - Cumberland</td> <td>09 - Hudson</td> <td>12 - Middlesex</td> <td>15 - Ocean</td> <td>18 - Somerset</td> <td>21 - Warren</td> </tr> </table>											01 - Atlantic	04 - Camden	07 - Essex	10 - Hunterdon	13 - Monmouth	16 - Passaic	19 - Sussex	02 - Bergen	05 - Cape May	08 - Gloucester	11 - Mercer	14 - Morris	17 - Salem	20 - Union	03 - Burlington	06 - Cumberland	09 - Hudson	12 - Middlesex	15 - Ocean	18 - Somerset	21 - Warren
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Admitting Diagnosis 22.																															

This form should be mailed within 48 hours to the local County Medical Assistance Unit.

MC-1C (1-70)

COUNTY COPY

COMB 3289C ED 1-70
 Printed in U.S.A.

REV. 7/16/70



STATE OF NEW JERSEY
 Department of Institutions and Agencies
 Division of Medical Assistance and Health Services

HOSPITAL PHARMACY RX REPORT

PATIENTS NAME		HEALTH SERVICES PROGRAM NO.		PERSON NO.
DRUG SUPPLIED				PROVIDER NO.
MANUFACTURER		COST		

QUANTITY DISPENSED	DAYS SUPPLY	DOSAGE FORM	STRENGTH	RX NUMBER	CHECK ONE		DATE DISPENSED
					ORIG RX	REFILL	

COMPLETE AND ATTACH TO OUTPATIENT CLAIM
 MC-4A WHEN TAKE HOME MEDICATIONS ARE DISPENSED.

MC-7 (1-70)

MEDICAID 33171 ED 3-70 (N.J.)
 Printed in U.S.A.