

(d) Once the Division approves the entity to be reimbursed as an outpatient hospital service, the Division or its settlement agent, as specified in N.J.A.C. 10:52-4.8, shall ensure that the information submitted is in compliance with (b) above. A review may occur at any time at the Division's discretion, including, but not limited to, the time of the audit of the hospital's cost report. If it is determined that the service provided by the entity is not provided consistent with the criteria for participation, as specified in (b) above, the Division shall notify the hospital of its denial of the service and disallow the costs and the related reimbursement for any time that service or entity was not in compliance with these rules.

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

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

- i. When access and/or availability to a particular service within a particular geographic area is limited; or
- ii. When the availability of transportation to a particular service within a particular geographical area is limited.

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

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

New Rule, R.1997 d.396, effective September 15, 1997.  
See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).  
Recodified from N.J.A.C. 10:52-1.2A and amended by R.2000 d.29, effective January 18, 2000.

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

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

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

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

Added (b)1ii.

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

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

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

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

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

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

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

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

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

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

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

ii. With the exception of mothers receiving benefits through the Emergency Services for Aliens Program, a mother who is a Medicaid beneficiary and her newborn shall have the same Medicaid Eligibility Identification Number when they are a part of the same household, but each shall be assigned his or her own Person Number. A

mother receiving benefits through the Emergency Services for Aliens Program shall be assigned a Medicaid Eligibility Identification Number, and her newborn shall be assigned a separate Medicaid Eligibility Identification Number after being determined eligible in accordance with N.J.A.C. 10:69 or N.J.A.C. 10:72, as applicable.

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

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

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

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

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

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

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

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

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

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

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

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

(b) When a patient is admitted to a hospital and is determined Medicaid eligible subsequent to the date of admission, charges incurred during the ineligible period of

the hospital stay shall not be reimbursable, unless coverage is pursued and approved under retroactive eligibility.

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

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

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

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

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

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

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

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

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

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

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

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

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

5. For beneficiaries in the Medically Needy Program, inpatient hospital services shall be available only to pregnant women. For information on how to identify a Medicaid beneficiary in the Medically Needy Program, refer to N.J.A.C. 10:49-2.3(c)4, Administration.

(b) The distribution of the GME payment to eligible acute care teaching hospitals is based on the hospital-specific percentage of total weighted GME FTEs, where weighted GME FTEs equals the hospital-specific GME FTEs times the hospital-specific Medicaid and NJ FamilyCare-Plan A fee-for-service days divided by the total Medicaid and NJ FamilyCare-Plan A hospital fee-for-service days for all eligible hospitals.

New Rule, R.1998 d.340, effective July 6, 1998.

See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).

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

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

In (b), deleted 1; substituted "FamilyCare" for "KidCare" throughout.

## SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

### 10:52-9.1 Review and appeal of rates

(a) All hospitals, within 15 working days of receipt of the Proposed Schedule of Rates shall notify the Division of any calculation errors in the rate schedule that relate to adjustments that have been made to the rates since the previously announced schedule of rates. If upon review it is determined by the Division that the error is of substantial value, a revised rate will be issued to the hospital within 10 working days. If the discrepancy is determined to be substantial and a revised Schedule of Rates is not issued by the Division within 10 working days, notification time frames above will not become effective until the hospital receives a revised Schedule of Rates.

(b) Any hospital which seeks an adjustment to its rates shall agree to an operational review at the discretion of the Department.

1. A request for a rate review must be submitted by a hospital in writing to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, PO Box 712, Mail Code #44, Trenton, New Jersey 08625-0712 within 20 calendar days after publication of the rates by the Department of Human Services (DHS).

i. A hospital shall identify its rate review issues and submit supporting documentation in writing to the Division within 80 calendar days after publication of the rates by the DHS.

2. The Division will not approve an increase in a hospital's rates unless the hospital demonstrates that it would sustain a marginal loss in providing inpatient services to Medicaid and NJ FamilyCare-Plan A fee-for-service beneficiaries at the rates under appeal even if it were an economically and efficiently operated hospital. Marginal loss is the amount by which a hospital's rate year's Medicaid and NJ FamilyCare-Plan A fee-for-service reimbursement for inpatient services including Graduate Medical Education (GME) and Disproportionate Share

Hospital (DSH) payments is expected to fall short of the incremental costs, defined as the variable or additional out of pocket costs, that the hospital expects to incur providing inpatient hospital services to Medicaid and NJ FamilyCare-Plan A fee-for-service patients during the rate year. These incremental costs are over and above the inpatient costs the hospitals would expect to incur during the rate year even if it did not provide service to Medicaid and NJ FamilyCare-Plan A fee-for-service patients. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid and NJ FamilyCare-Plan A fee-for-service beneficiaries and the extent to which it has taken all reasonable steps to contain or reduce the costs of providing inpatient hospital services. The hospital may be required at a minimum to submit to the Department of Human Services, the following information:

- i. Operational reviews;
- ii. Efficiency studies and reports identifying opportunities for cost savings;
- iii. Minutes of the meeting of the hospital's board of directors and board's finance committee;
- iv. Reports of the Joint Commission on the Accreditation of Health Care Organizations;
- v. Management letters;
- vi. The hospital's strategic plans, long range plans, facilities plans and marketing plans;
- vii. The hospital's annual report;
- viii. Any analyses of the hospital's marginal cost in providing services to Medicaid and NJ FamilyCare-Plan A fee-for-service or other categories of patients;
- ix. Cost accounting documentation or reports pertaining to the hospital's cost incurred in treating Medicaid and NJ FamilyCare-Plan A fee-for-service beneficiaries or the comparative cost of treating Medicaid and NJ FamilyCare-Plan A fee-for-service and other patients;
- x. A copy of the hospital's most recent Medicare cost report with all supporting schedules;
- xi. Contracts with other payors providing for negotiated rates or discounts from billed charges; and
- xii. Evidence that the appealed rates jeopardize the long term financial viability of the hospital (that is, that the hospital is sustaining a marginal loss in treating Medicaid and NJ FamilyCare-Plan A fee-for-service beneficiaries) and that the hospital is necessary to provide access to care for Medicaid and NJ FamilyCare-Plan A fee-for-service beneficiaries.

(c) The Division shall review the documentation and determine if an adjustment is warranted.

(d) The Division shall issue a written determination with an explanation as to each request for a rate adjustment. If a hospital is not satisfied with the Division's determination, the hospital may request an administrative hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an administrative hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying or rejecting the Administrative Law Judge's initial Office of Administrative Law decision. Thereafter, review may be had in the Appellate Division.

Amended by R.1995 d.141, effective March 6, 1995.

See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

Amended by R.1997 d.43, effective January 21, 1997.

See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Added (b)2, inserted provisions defining marginal loss and incremental costs; and in (d), inserted provision providing time period for an administrative hearing request.

Amended by R.1997 d.541 effective December 15, 1997 (operative January 1, 1998).

See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).

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

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

In (b), substituted a reference to the Office of Reimbursement Services for a reference to the Office of Budget, Fiscal Affairs and Information Systems in 1, and substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare Plan—A fee-for-service throughout 2.

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

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

In (a), rewrote the first sentence; in (b), deleted "of Human Services" following "Department" in the introductory paragraph, substituted "Hospital Reimbursement" for "Reimbursement Services" and "44" for "49" in the introductory paragraph of 1, and inserted "including Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments" following "inpatient services" in 2; substituted "FamilyCare" for "KidCare" throughout.

#### Case Notes

Initial Decision (1998 N.J. AGEN LEXIS 236) adopted, which concluded that the Division of Medical Assistance and Health Services (DMAHS) properly denied hospital's request for a rate review based on hospital's failure to submit information responsive to one or more of the regulatory criteria. In re St. Francis Med. Center (Trenton), OAL Dkt. No. HMA 2252-96, 1998 N.J. AGEN LEXIS 1108, Final Decision (May 1, 1998).

Existence of state's administrative process did not preempt hospital association's action to enjoin state from using its revised rate setting methodology for general inpatient hospital services. *New Jersey Hosp. Ass'n v. Waldman*, 73 F.3d 509 (3rd Cir. N.J. 1995).

New Jersey Division of Medical Assistance and Health Services' calculation method for the years 1996 to 2001 with regard to determining whether hospitals had sustained a marginal loss pursuant to N.J.A.C. 10:52-9.1(b)(2), as the result of providing inpatient services to Medicaid and NJ FamilyCare-Plan A recipients, properly utilized Disproportionate Share Hospitals payments. The Division's use of Medicaid costs contained in hospital Medicare cost reports in making its calculations was also upheld. In re Hospitals' Petitions For Adjustment of Rates For Reimbursement of Inpatient Services to Medicaid Beneficiaries, 383

N.J. Super. 219, 891 A.2d 641, 2006 N.J. Super. LEXIS 42 (App.Div. 2006).

Remand of Medicaid rate appeal by hospitals was required, where Division of Medical Assistance failed to provide reasons for its decisions that errors in rates alleged by hospitals were not calculation errors, that requests for rate relief must be pursued under special procedure for rate appeal, and that alleged calculation errors were not substantial. *Atlantic City Med. v. Squarrell*, 349 N.J. Super. 16, 793 A.2d 10 (App.Div. 2002).

Decision by the acting commissioner summarily rejecting hospitals' appeals seeking reimbursement of Medicaid inpatient hospital costs was arbitrary and capricious and an abdication of the responsibility under the Division of Medical Assistance and Health Services' own regulations to consider these appeals on the merits. In re Zarbrugg Mem. Hospital, 349 N.J. Super. 27, 793 A.2d 17 (App.Div. 2002).

Decisions by the Division of Medical Assistance and Health Services to consider only a single issue found to be dispositive of hospitals' Medicaid rate appeals did not violate any of the statutory or regulatory provisions governing the Medicaid program or constitute an abuse of discretion. *Hospital Center at Orange v. Guhl*, 331 N.J. Super. 322, 751 A.2d 1077 (App.Div. 2000).

Regulations promulgated by state department of human services regarding hospital rates for Medicaid patients were valid where they allowed hospitals to challenge impact of designation of labor market areas as part of rate adjudication process. *Matter of Adoption of N.J.A.C. 10:52-5.14(d)2 and 3*, 276 N.J. Super. 568, 648 A.2d 509 (App.Div. 1994), certification denied 142 N.J. 448, 663 A.2d 1355.

Denial of Medicaid rates review upheld due to hospital's failure to submit sufficient information. In re: *St. Mary's Hospital (Hoboken) 1995 Medicaid Rates*, 97 N.J.A.R.2d (DMA) 65.

Denial of Medicaid rates review upheld due to hospital's failure to submit sufficient information. In re *Palisades General Hospital, 1995 Medicaid Rates*, 97 N.J.A.R.2d (DMA) 61.

Denial of Medicaid rates review upheld due to hospital's failure to submit sufficient information. In re *Hackettstown Community Hospital's 1995 Medicaid Rates*, 97 N.J.A.R.2d (DMA) 57.

Adjustment letter insufficient notice of Medicaid rate change reversed. In the *Matter of Cathedral Healthcare System, Inc., 1994 Medicaid Rates*, 97 N.J.A.R.2d (DMA) 54.

Hospital's challenge to proposed schedule of Medicaid reimbursement rate untimely if filed six months later. *Saint Peter's Medical Center v. Division of Medical Assistance and Health Services*, 97 N.J.A.R.2d (DMA) 51.

Hospital's rate request will be denied if it fails to show loss attributable to rendering Medicaid services while running efficient and economically-operated facility. *Newcomb Medical Center v. Division of Medical Assistance and Health Services*, 97 N.J.A.R.2d (DMA) 46.

Denial of Medicaid rates appeal upheld due to hospital's failure to submit sufficient information. In *Re Cathedral Healthcare System, Inc.*, 97 N.J.A.R.2d (DMA) 27.

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

### 10:52-10.1 Introduction

(a) The New Jersey Medicaid/FamilyCare fee-for-service program utilizes the Healthcare Common Procedure Coding

System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology architecture, employing a five position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the

CMS assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three level coding system.

1. LEVEL I CODES (Narratives found in CPT)