

CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D-7 and 12.

Source and Effective Date

R.2000 d.29, effective December 21, 1999.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Executive Order No. 66(1978) Expiration Date

Chapter 52, Hospital Services Manual, expires on December 21, 2004.

Chapter Historical Note

Chapter 52, Manual for Hospital Services, was adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c).

Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, Coverage, was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b).

Pursuant to Executive Order No. 66(1978), Subchapter 2, Admissions and Billing Procedures, was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1992 d.327, effective August 17, 1992, operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a).

Subchapter 5, Procedural and Methodological Regulations, Subchapter 6, Financial Reporting Principles and Concepts, Subchapter 7, Diagnosis Related Groups (DRG), Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993, to expire May 10, 1993. See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 1582(a), 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Hospital Services Manual, was readopted as R.1995 d.123, effective February 3, 1995, and Subchapter 1, Coverage, Subchapter 2, Admission and Billing Procedures, Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric Services, Subchapter 4, Basis of Payment for Hospital Services, and Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, were adopted as new rules by R.1995 d.123, effective April 17, 1995. See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Subchapter 10, Charity Care, was adopted as R.1995 d.258, effective May 15, 1995. See: 27 N.J.R. 656(a), 27 N.J.R. 1995(a).

Subchapter 12, Graduate Medical Education and Indirect Medical Education, was adopted as R.1997 d.43, effective January 21, 1997. See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was adopted as R.1997 d.520, effective January 5, 1998. See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Hospital Services Manual, was readopted as R.2000 d.29, effective December 21, 1999, and Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, was recodified as Subchapter 13, Eligibility for and Basis of Payment for Disproportionate Share Hospitals, Subchapter 10, Charity Care, was recodified as Subchapter 11, Charity Care, Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was recodified as Subchapter 12, Charity Care Component of the Disproportionate Share Hospital Subsidies, Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, was recodified as Subchapter 10, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, and Subchapter 12, Graduate Medical Education and Indirect Medical Education, was recodified as Subchapter 8, Graduate Medical Education and Indirect Medical Education, by R.2000 d.29, effective January 18, 2000. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:52-1.1 Purpose and scope
- 10:52-1.2 Definitions
- 10:52-1.2A (Reserved)
- 10:52-1.3 Criteria for participation: outpatient hospital services
- 10:52-1.4 Use of PA-1C for applying for benefits for a hospital patient
- 10:52-1.5 Eligibility of beneficiary for hospital services
- 10:52-1.6 Covered services (inpatient and outpatient)
- 10:52-1.7 Offset of disproportionate share hospital payments
- 10:52-1.8 Non-covered services (inpatient and outpatient)
- 10:52-1.9 Administrative days (nursing facility level of care)—general, special (Classification A & B) and private psychiatric hospitals
- 10:52-1.10 Prior authorization
- 10:52-1.11 Pre-admission screening for nursing facility (NF) placement
- 10:52-1.12 Recordkeeping
- 10:52-1.13 Second opinion program for elective surgical procedures
- 10:52-1.14 Social Necessity Days
- 10:52-1.15 Utilization control (inpatient services)
- 10:52-1.16 Utilization control: inpatient psychiatric services for beneficiaries under 21 years of age in private psychiatric hospitals
- 10:52-1.17 Utilization control; outpatient psychiatric services
- 10:52-1.18 Advance directives

SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

- 10:52-2.1 Ambulatory Surgical Center (ASC)
- 10:52-2.2 Blood and blood products
- 10:52-2.3 Dental services
- 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- 10:52-2.5 Family planning services
- 10:52-2.6 Home health agencies; hospital-based
- 10:52-2.7 Medical day care centers; hospital affiliated
- 10:52-2.8 Narcotic and drug abuse treatment centers; free-standing
- 10:52-2.9 Organ procurement and transplantation services
- 10:52-2.10 Psychiatric services; partial hospitalization
- 10:52-2.11 Rehabilitative services; hospital outpatient department
- 10:52-2.12 Renal dialysis services for end-stage renal disease (ESRD)
- 10:52-2.13 Sterilization
- 10:52-2.14 Hysterectomy
- 10:52-2.15 Termination of pregnancy
- 10:52-2.16 Transportation services; hospital-based

SUBCHAPTER 3. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES

- 10:52-3.1 Purpose
- 10:52-3.2 Scope of services
- 10:52-3.3 HealthStart provider participation criteria
- 10:52-3.4 Termination of HealthStart certificate
- 10:52-3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate
- 10:52-3.6 Access to services
- 10:52-3.7 Plan of Care (PoC)
- 10:52-3.8 Maternity Medical Care services
- 10:52-3.9 HealthStart health support services
- 10:52-3.10 Professional staff requirements for HealthStart Comprehensive Maternity Care services
- 10:52-3.11 Records; documentation, confidentiality and informed consent requirements for HealthStart Comprehensive Maternity Care providers
- 10:52-3.12 Standards for HealthStart Pediatric Care Certificate
- 10:52-3.13 Professional requirements for HealthStart Pediatric Care providers
- 10:52-3.14 Preventive care services provided by HealthStart Pediatric Care providers
- 10:52-3.15 Records; documentation, confidentiality and informed consent for HealthStart Pediatric Care Providers
- 10:52-3.16 Reimbursement for HealthStart providers
- 10:52-3.17 HealthStart Maternity Care billing code requirements

SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

- 10:52-4.1 Basis of payment; acute general hospitals reimbursed under the Diagnosis Related Groups (DRG) system—inpatient services
- 10:52-4.2 Basis of payment; special hospitals (Classification A and B), private and governmental psychiatric hospitals and distinct (excluded units) of acute general hospitals—inpatient services
- 10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care hospitals—outpatient services
- 10:52-4.4 Basis of payment and appeal procedure; out-of-State hospital services
- 10:52-4.5 Reimbursement for third-party claims
- 10:52-4.6 Medicare/Medicaid or Medicare/NJ KidCare claims
- 10:52-4.7 Personal contribution to care requirements for NJ KidCare—Plan C and copayments for NJ KidCare—Plan D
- 10:52-4.8 Settlement for Medicaid/NJ KidCare fee-for-service services

SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

- 10:52-5.1 Derivation of Preliminary Cost Base
- 10:52-5.2 Uniform Reporting: Current costs
- 10:52-5.3 Costs per case
- 10:52-5.4 Development of standards
- 10:52-5.5 Current Cost Base
- 10:52-5.6 Financial elements reporting/audit adjustments
- 10:52-5.7 Identification of direct and indirect costs related to Medicaid/NJ KidCare patient care
- 10:52-5.8 Patient care cost findings; direct costs per case, physician and nonphysician
- 10:52-5.9 Reasonable cost of services related to patient care
- 10:52-5.10 Standard costs per case
- 10:52-5.11 Reasonable direct cost per case
- 10:52-5.12 Net income from other sources
- 10:52-5.13 Update Factors
- 10:52-5.14 Capital facilities
- 10:52-5.15 Division adjustments and approvals
- 10:52-5.16 Derivation from Preliminary Cost Base
- 10:52-5.17 Schedule of rates—effective date
- 10:52-5.18 through 10:52-5.21 (Reserved)

SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

- 10:52-6.1 Reporting period
- 10:52-6.2 Objective evidence
- 10:52-6.3 Consistency
- 10:52-6.4 Full disclosure
- 10:52-6.5 Materiality
- 10:52-6.6 Basis of Valuation
- 10:52-6.7 Accrual accounting
- 10:52-6.8 Accounting for minor moveable equipment
- 10:52-6.9 Accounting for capital facilities costs
- 10:52-6.10 Timing differences
- 10:52-6.11 Self-insurance
- 10:52-6.12 Related organizations
- 10:52-6.13 Financial elements (generally)
- 10:52-6.14 Services related to Medicaid/NJ KidCare fee-for-service patient care
- 10:52-6.15 Direct patient care
- 10:52-6.16 Paid taxes
- 10:52-6.17 Educational, research and training program
- 10:52-6.18 Capital facilities
- 10:52-6.19 Major moveable equipment
- 10:52-6.20 Natural classifications of expense
- 10:52-6.21 Medical and Surgical Supplies
- 10:52-6.22 Non-Medical and Non-Surgical Supplies
- 10:52-6.23 Purchased Services
- 10:52-6.24 Major Moveable Equipment
- 10:52-6.25 Reports of costs and revenues
- 10:52-6.26 Excluded health care services
- 10:52-6.27 Education and research
- 10:52-6.28 Sales and services not related to patient care
- 10:52-6.29 Patient convenience items
- 10:52-6.30 Administrative items
- 10:52-6.31 Non-operating revenues (net of expenses)
- 10:52-6.32 Reporting of costs and revenues
- 10:52-6.33 Medical-Surgical Acute Care Units (MSA)
- 10:52-6.34 Obstetric Acute Care Unit (OBS)
- 10:52-6.35 Pediatric Acute Care Units (PED)
- 10:52-6.36 Psychiatric Acute Care Units (PSA)
- 10:52-6.37 Burn Care Units (BCU)
- 10:52-6.38 Intensive Care Units (ICU)
- 10:52-6.39 Coronary Care Units (CCU)
- 10:52-6.40 Neonatal Intensive Care Units (NNI)
- 10:52-6.41 Newborn Nursery (NBN)
- 10:52-6.42 Emergency Services (EMR)
- 10:52-6.43 Anesthesiology Services (ANS)
- 10:52-6.44 Cardiac Catheterization (CCA)
- 10:52-6.45 Delivery and Labor Rooms (DEL)
- 10:52-6.46 Dialysis (DIA)
- 10:52-6.47 Drugs Sold to Patients (DRU)
- 10:52-6.48 Electrocardiology (EKG)
- 10:52-6.49 Laboratory (LAB)
- 10:52-6.50 Medical and Surgical Supplies Sold (MSS)
- 10:52-6.51 Neurology, Diagnostic (NEU)
- 10:52-6.52 Nuclear Medicine (NMD)
- 10:52-6.53 Occupational and Recreational Therapy (OCC)
- 10:52-6.54 Operating and Recovery Rooms (ORR)
- 10:52-6.55 Organ Acquisition (ORG)
- 10:52-6.56 Physical Therapy (PHT)
- 10:52-6.57 Psychiatric/Psychological Services (PSY)
- 10:52-6.58 Radiology, Diagnostic (RAD)
- 10:52-6.59 Respiratory Therapy (RSP)
- 10:52-6.60 Speech-Language Pathology and Audiology (SPA)
- 10:52-6.61 Therapeutic Radiology (THR)
- 10:52-6.62 Central Supply Services (CSS)
- 10:52-6.63 Dietary (DTY)
- 10:52-6.64 Housekeeping (HKP)
- 10:52-6.65 Laundry and Linen (L&L)
- 10:52-6.66 Medical Records (MRD)
- 10:52-6.67 Pharmacy (PHM)
- 10:52-6.68 Social Services (SOC)
- 10:52-6.69 Research (RSH)
- 10:52-6.70 Nursing and Allied Health Education (EDU)
- 10:52-6.71 Graduate Medical Education (GME)

- 10:52-6.72 General Administrative Services (GAM)
- 10:52-6.73 Inpatient Administrative Services (IAM)
- 10:52-6.74 Malpractice Insurance (MAL)
- 10:52-6.75 Employee Health Insurance (EHI)
- 10:52-6.76 Repairs and Maintenance (RPM)
- 10:52-6.77 Utilities Cost (UTC)
- 10:52-6.78 through 10:52-6.79 (Reserved)

SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

- 10:52-7.1 Diagnosis Related Groups (DRG)
- 10:52-7.2 Calculation of Payment Rates
- 10:52-7.3 List of Diagnosis Related Groups

SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

- 10:52-8.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed
- 10:52-8.2 Distribution of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement
- 10:52-8.3 Establishment of GME and IME interim method of reimbursement
- 10:52-8.4 Establishment of GME and IME final method of reimbursement
- 10:52-8.5 Hospital fee-for-service reimbursement for Graduate Medical Education (GME) effective on or after July 6, 1998
- 10:52-8.6 Distribution of Graduate Medical Education (GME) effective on or after July 6, 1998

SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

- 10:52-9.1 Review and appeal of rates

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

- 10:52-10.1 Introduction
- 10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory
- 10:52-10.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT)
- 10:52-10.4 Pathology and Laboratory HCPCS Codes—Qualifiers
- 10:52-10.5 Pathology and Laboratory HCPCS Codes—Modifiers

SUBCHAPTER 11. CHARITY CARE

- 10:52-11.1 Charity care audit functions
- 10:52-11.2 Sampling methodology
- 10:52-11.3 Charity care write off amount
- 10:52-11.4 Differing documentation requirements if patient admitted through emergency room
- 10:52-11.5 Charity care screening and documentation requirements
- 10:52-11.6 Identification
- 10:52-11.7 New Jersey residency
- 10:52-11.8 Income eligibility criteria and documentation
- 10:52-11.9 Proof of income
- 10:52-11.10 Assets eligibility criteria
- 10:52-11.11 Limit on accounts with alternative documentation
- 10:52-11.12 Additional information to be supplied to facility by applicant
- 10:52-11.13 Application and determination
- 10:52-11.14 Collection procedures and prohibited action
- 10:52-11.15 Adjustment methodology
- 10:52-11.16 Charity care applications of patients admitted through emergency room
- 10:52-11.17 Charity care applications of patients admitted through the emergency room between January 1, 1999, and July 17, 2000

SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

- 10:52-12.1 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund
- 10:52-12.2 Basis of pricing for charity care claims

SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

- 10:52-13.1 Disproportionate share adjustment—general eligibility
- 10:52-13.2 Disproportionate share hospital (DSH) payment—general
- 10:52-13.3 Eligibility and disproportionate share hospital payments for hospitals operating under N.J.S.A. 18A:64G-1
- 10:52-13.4 Eligibility for and disproportionate share hospital payments from the Charity Care Component of the Health Care Subsidy Fund
- 10:52-13.5 Eligibility for and payment of Hospital Relief Subsidy Fund DSH
- 10:52-13.6 Eligibility and payment for DSH funding from the Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients
- 10:52-13.7 Calculation and distribution of Disproportionate Share Hospital (DSH) payments as a result of a hospital closure: purpose and procedure

APPENDIX. FISCAL AGENT BILLING SUPPLEMENT

SUBCHAPTER 1. GENERAL PROVISIONS

10:52-1.1 Purpose and scope

(a) This chapter outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid and NJ KidCare fee-for service beneficiaries. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and psychiatric hospitals, unless specifically indicated otherwise.

(b) Unless otherwise stated, the rules of this chapter apply to Medicaid and NJ KidCare—Plan A, B and C fee-for-service beneficiaries and to Medicaid and NJ KidCare—Plan A, B, C and D fee-for-service services which are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services which are to be provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO.

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).
Amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted a reference to Medicaid and NJ KidCare fee-for service beneficiaries for a reference to Medicaid recipients, and substituted a reference to psychiatric hospitals for a reference to private psychiatric hospitals; and added (b).

10:52-1.2 Definitions

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

“Base year” means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

“Bundled drug service” means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost of the drug, the drug product and ancillary services, such as, but not limited to, case management and laboratory services.

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

“DHSS” means the State Department of Health and Senior Services.

“Diagnosis Related Groups (DRGs)” means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications, and consumption of a similar amount of resources.

“Division” means the New Jersey Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid and NJ KidCare-Plan A beneficiaries under 21 years of age or age 19 for NJ KidCare-Plan A for the purpose of assessing a beneficiary’s health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

“Entity,” as used in N.J.A.C. 10:52-1.2A, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

“Equalization Factor” means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs in setting Statewide standard costs per case.

“Financial Elements” means the reasonable cost of items approved as reimbursable under Medicaid (see N.J.A.C. 10:52-5.10).

“Grouper” means the logic that assigns cases into the appropriate Diagnosis Related Groups in accordance with the clinical and statistical information supplied.

“Hospital” means, pursuant to section 1861(e) of the Social Security Act (42 U.S.C. § 1395x(e)), an institution which is primarily engaged in providing the following services to inpatients, by or under the supervision of physicians:

1. Diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or,
2. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; and
3. Maintains clinical records on all patients;
4. Has by-laws in effect with respect to its staff of physicians;
5. Requires every patient to be under the care of a physician;
6. Provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a registered professional nurse or licensed practical nurse on duty at all times;
7. Has in effect a hospital utilization review plan that meets the requirement of the law (Sec. 1861(K) of the Social Security Act); and has in place a discharge planning process that meets the requirements of the law (Sec. 1861(ee)) of the Social Security Act;
8. Is licensed as a hospital in the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located, or approved by the agency of the state or locality responsible for licensing hospitals meeting the standards established for such licensing;
9. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of health and safety of individuals who furnished services in the institution; and
10. For the purposes of N.J.A.C. 10:52-1.2A only, is where the main inpatient hospital services are located.

“Hospital (Approved General)” means an institution which is approved to participate as a provider in the Division if it:

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid/NJ KidCare provider);
2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act);

3. Has in effect a hospital utilization review plan applicable to all patients who received medical assistance under Medicaid (Title XIX) and NJ KidCare (Title XXI); and

4. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

“Hospital (Approved Private Psychiatric)” means an institution which is approved to participate as a provider in the Division and:

1. Is licensed by the State of New Jersey as a psychiatric (mental-non-governmental) hospital or licensed as a private psychiatric hospital (non-governmental) by the appropriate agency under the laws of the respective state in which the hospital is located;

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a psychiatric hospital;

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX);

4. Meets the special Medicare standards relative to staffing requirements and clinical medical records; and,

5. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

“Hospital (Approved Private Psychiatric) facility that provides inpatient services to children under 21 years of age” means an institution that shall meet the requirements of 1., 2., 3., 4. and 5. above, listed in the definition of “Hospital (Approved Private Psychiatric): or in addition to 1. and 5. above, has facility accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

“Hospital (Approved Special)” means an institution which is approved by the New Jersey State Department of Health and Senior Services as a special hospital (for definition of special hospital, see N.J.A.C. 8:43G-1.3(b)2) and which includes any hospital which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation, where applicable, on an inpatient basis for one or more specific categories of patients; and approved to participate as a provider in the Division if it meets the appropriate standards of participation for one of the following classifications:

1. Special (Acute care or short term) or Comprehensive Rehabilitation Hospital:

i. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health and Senior Services;

ii. Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the

Commission on Accreditation as a hospital or rehabilitation facility; and/or

iii. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a hospital;

iv. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

v. Has signed a provider agreement to participate in and abide by the rules of the Division and all applicable Federal regulations.

“Inliers” means inpatient cases who display common or typical patterns of resource use that are assigned to DRGs and have a length of stay within the high and low trim points.

“Inpatient” means a patient who has been admitted to an approved hospital as an inpatient on the recommendation of a physician, dentist or nurse midwife and receives room, board, and professional services in the hospital for a 24 hour period or longer, even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the hospital for 24 hours.

“Inpatient Hospital Services” means services that:

1. Are ordinarily furnished in a hospital for the care and treatment of inpatients;

2. Are furnished under the direction of a physician or dentist, except, as specified in 42 CFR 440.165 of the Social Security Act, for services provided by a certified nurse midwife;

3. Are furnished in an institution that:

i. Is maintained primarily for the care and treatment of patients with disorders including obstetrical services and services to the normal newborn;

ii. Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

iii. Except in the case of medical supervision of nurse-midwife services, as specified in 42 CFR 440.165 of the Social Security Act, or private inpatient psychiatric facilities for children under 21 years of age, meets the requirements for participation in Medicare as a hospital; and,

iv. Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30 of the Social Security Act, unless a waiver has been granted by the U.S. Secretary of Health and Human Services.

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

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

“Nontherapeutic sterilization” means any procedure or operation, the purpose of which is to render an individual permanently incapable of reproducing and which is not either a necessary part of the treatment of an existing illness or injury, or medically indicated as an accompaniment of an operation on the female genitourinary tract. For the purpose of this definition, mental incapacity is not considered an illness or injury.

“Outliers” means patients who display atypical characteristics relative to other patients in a DRG and have lengths of stay either above or below the established trim points.

“Outpatient” means a patient registered in the outpatient department of a hospital or in a distinct part of that hospital who is expected to receive and who does receive professional services for less than a 24 hour period, regardless of the hour of admission; or whether or not a bed is used; or whether or not the patient remains in the hospital past midnight.

“Outpatient hospital services” means medically necessary items or services (preventive, diagnostic, rehabilitative, therapeutic, or palliative) provided to an outpatient by or under the direction of a physician or dentist, except for the medical supervision of nurse midwife services; and/or by a psychiatric hospital or an excluded unit of a general hospital and the institution is licensed or formally approved as a hospital by the New Jersey State Department of Health and Senior Services, or certified by the officially designated authority in the state in which the hospital is located; meets the requirements for participation in Medicare (Title XVI-II) as a hospital; and meets the criteria for participation as stated in N.J.A.C. 10:52-1.3.

“Patient” means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

“Physician” means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

“Physician services” means those services provided within the scope of practice of a doctor of medicine (M.D.) or osteopathy (D.O.) as defined by the laws of New Jersey, or if in practice in another state by the laws of that state, and which services are performed by or under the direction and/or personal supervision of the physician. (See also N.J.A.C. 10:54-1.2.)

“Preliminary Cost Base (PCB)” means the estimated revenue a hospital may collect based on an approved schedule of rates which includes DRG rate amounts and indirect costs not included in the all-inclusive rate. Those indirect costs will either be the dollar amount specified or the estimated amount determined by a specific percentage adjustment to the rate.

“Rate year” means the year in which current reimbursement takes place.

“Trim points” means the high and low length of stay cutoff points assigned to each DRG.

“Uniform Bill—Patient Summary (UB-92)” means the common billing and reporting form used by the hospital for each Medicaid inpatient.

Amended by R.1997 d.396, effective September 15, 1997.
See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).

Added “Entity”; and amended “Hospital” and “Outpatient hospital services”.

Amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Deleted “Adjusted admissions” and “Informed Consent”; inserted “DHSS”; in “Early and Periodic Screening, Diagnosis and Treatment (EPSDT)”, substituted references to Medicaid and NJ KidCare—Plan A beneficiaries for references to Medicaid recipients, and inserted “or age 19 for NJ KidCare—Plan A beneficiaries” following “age”; in “Hospital”, inserted a reference to 42 U.S.C. § 1395x(e) in the introductory paragraph; in Hospital (Approved General), inserted references to NJ KidCare in 1 and 3; in “Hospital (Approved Special)”, made internal designation changes; in “Inpatient”, inserted a reference to nurse midwives; in “Outpatient hospital services”, substituted “a psychiatric hospital or an excluded unit of a general hospital and the institution” for “private inpatient psychiatric facility for patients under 21 and over 65 years of age; and the institution that” following “and/or by”, and changed N.J.A.C. reference; and changed “Uniform Bill—Patient Summary (UB-PS or UB-92)” definition to “Uniform Bill—Patient Summary (UB-92)”.

Case Notes

No reimbursement for inpatient services provided while patient awaiting placement in skilled nursing care facility. *Monmouth Med. Center v. State*, 158 N.J.Super. 241 (App.Div.1978), affirmed 80 N.J. 299 (1979), certiorari denied 444 U.S. 942 (1979).

Consent; bilateral salpingectomy and hysterectomy; purposes of Medicaid Reimbursement. *Centra State Medical Center v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 65.

10:52-1.2A (Reserved)

Recodified to N.J.A.C. 10:52-1.3 by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

10:52-1.3 Criteria for participation: outpatient hospital services

(a) The Division shall reimburse approved hospitals to provide covered outpatient hospital services, where applicable, in accordance with all the provisions of this chapter. In order to be approved and reimbursed as an outpatient hospital service, effective in accordance with the dates in (c) below, each site that provides an outpatient hospital service for which the hospital bills the Medicaid or NJ KidCare fee-for-service program as an outpatient hospital service shall have been approved by the Division of Medical Assistance and Health Services (known as the “Division”), in accordance with this rule. Such approval shall include sites located in the main inpatient hospital, and both the contiguous and non-contiguous sites.

(b) The responsibility of the provider when rendering specific services and requesting reimbursement is listed in both Subchapter 1 and Subchapter 2 of N.J.A.C. 10:52, Hospital Services.

(c) Regarding specific elements of HCPCS codes which requires attention of provider, the lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code identified under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," and "MAXIMUM FEE ALLOWANCE." The information identified under each column is summarized below:

Column Title	Description
IND	(Indicator Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid and NJ KidCare fee-for-service program's qualifications and requirements when a procedure or service code is used. Explanation of indicators and qualifiers used in this column are identified below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. "F" preceding any procedure code indicates that this code, when used primarily for the diagnosis and treatment of infertility, is not covered by the New Jersey Medicaid or NJ KidCare program. "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:52-10.3. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:52-10.4.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes are listed at N.J.A.C. 10:52-10.5.
DESCRIPTION	Lists the code narrative. (Narratives for Level I codes are found in CPT. Narratives for Level II and Level III codes are found at N.J.A.C. 10:52-10.3.)
MAXIMUM FEE ALLOWANCE	Lists the New Jersey Medicaid and NJ KidCare fee-for-service program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "S.C.C." (Subject Cost-to-Charge) are listed instead of a dollar amount, it means that service is subject to the cost-to-charge ratio. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable.

1. The fee listed under "Office Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

2. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp" and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

(d) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in CPT-4. The provider will then be liable for the additional requirements and not just the CPT/HCPCS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

Amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT-4 throughout; in (a), inserted a reference to Certified Nurse Practitioners in 1, and changed N.J.A.C. reference in 3; and in (c), inserted a reference to NJ KidCare.

10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp
N	36415		1.80	
N	80002		5.00	
N	80003		5.90	
N	80004		5.90	
N	80005		5.90	
N	80006		5.90	
N	80007		7.10	
N	80008		7.10	
N	80009		7.10	
N	80010		7.50	
N	80011		7.50	
N	80012		7.50	
N	80016		7.50	
N	80018		11.00	
N	80019		11.00	
N	80050		36.00	
N	80055		15.00	
N	80058		5.90	

Ind	HCPCS Code	Mod	Maximum Fee Allowance		Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp				Office Total Fee	\$ Prof. Comp
N	80059		30.00			82009		5.00	
N	80061		15.00			82010		10.00	
N	80072		12.00			82013		14.00	
N	80090		28.80			82024		30.00	
N	80091		12.00			82030		34.00	
	80092		37.00		A	82040		1.80	
	80100		5.20			82042		4.30	
	80101		5.20			82043		4.30	
	80102		15.00			82044		1.00	
	80150		15.00			82055		4.50	
	80152		15.00			82075		8.80	
	80154		21.50			82085		13.75	
	80156		20.00			82088		40.00	
	80158		20.00			82101		16.30	
	80160		15.00			82103		7.80	
	80162		15.00			82104		7.80	
	80164		10.00			82105		10.20	
	80166		15.00			82106		10.20	
	80168		24.50			82108		38.00	
	80170		12.60			82128		12.90	
	80172		1.80			82130		25.00	
	80174		15.00			82131		24.00	
	80176		18.00			82135		20.00	
	80178		9.00			82140		6.00	
	80182		12.00			82143		4.20	
	80184		12.80			82145		12.00	
	80185		19.00		A	82150		4.50	
	80186		19.00			82154		40.00	
	80188		20.00			82157		29.00	
	80190		15.00			82160		38.00	
	80192		15.00			82163		21.00	
	80194		15.00			82164		20.00	
	80196		7.00			82172		20.00	
	80198		15.00			82175		7.20	
	80200		12.60			82180		3.60	
	80202		12.00			82190		S.C.C.	
	80299		10.80			82205		12.00	
	80400		34.00			82232		24.50	
	80402		96.00			82239		20.00	
	80406		98.00			82240		5.69	
	80408		130.00		A	82250		3.00	
	80410		127.00		A	82251		4.50	
	80412		S.C.C.			82252		2.50	
	80414		61.00			82270		1.20	
	80415		50.00			82273		3.70	
	80418		S.C.C.			82286		7.60	
	80420		74.00			82300		30.00	
	80422		45.00			82306		30.00	
	80424		33.00			82307		25.00	
	80426		130.00			82308		34.00	
	80428		60.00		A	82310		3.00	
	80430		73.00			82330		14.70	
	80432		125.00			82331		7.50	
	80434		100.00			82340		3.60	
	80435		95.00			82355		9.00	
	80436		75.00			82360		12.00	
	80438		50.00			82365		9.00	
	80439		100.00			82370		9.00	
	80440		60.00		A	82374		3.30	
	80500		9.00			82375		6.00	
	80502		13.00			82376		3.00	
	81000		1.20			82378		22.40	
	81002		1.00			82380		6.00	
	81003		1.50			82382		12.00	
	81005		1.00			82383		12.00	
	81007		3.82			82384		18.00	
	81015		.40			82387		24.00	
	81025		3.00			82390		6.00	
	81050		3.40			82397		21.00	
	82000		15.00			82415		18.50	
	82003		26.00		A	82435		3.00	

Ind	HCPCS Code	Mod	Maximum Fee Allowance		Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp				Office Total Fee	\$ Prof. Comp
	82436		3.00			82787		49.00	
	82438		3.00			82800		5.20	
	82441		8.92			82803		16.50	
A	82465		3.00			82805		8.00	
	82480		4.50			82810		10.00	
	82482		11.27			82820		14.92	
	82485		30.00			82926		6.00	
	82486		4.40			82928		6.00	
N	82487		4.00			82938		26.00	
N	82488		15.00			82941		16.00	
N	82489		15.00			82943		20.00	
	82491		21.50			82946		13.00	
	82495		30.00		A	82947		4.34	
	82507		40.00			82948		1.50	
	82520		17.00			82950		3.00	
	82525		9.00			82951		5.00	
	82528		19.70			82952		1.00	
	82530		17.00			82953		10.00	
	82533		17.00			82955		6.00	
	82540		3.00			82960		7.00	
A	82550		4.80			82962		2.60	
	82552		7.80			82963		26.50	
	82553		7.50			82965		6.30	
	82554		16.00			82975		22.00	
A	82565		3.00		A	82977		4.80	
	82570		3.00			82978		12.00	
	82575		4.50			82979		10.00	
	82585		6.30			82980		20.00	
	82595		1.50			82985		6.60	
	82600		27.50			83001		17.00	
	82607		15.00			83002		17.00	
	82608		15.00			83003		16.00	
	82615		11.50			83008		24.00	
	82626		37.00			83010		12.00	
	82627		33.00			83012		12.00	
	82633		43.50			83015		10.20	
	82634		39.00			83018		25.00	
	82638		18.00			83020		6.00	
	82646		25.30			83026		2.00	
	82649		31.00			83030		12.00	
	82651		33.00			83033		7.00	
	82652		55.00			83036		6.60	
	82654		13.60			83045		1.50	
	82664		13.60			83050		3.00	
	82666		22.00			83051		1.20	
	82668		17.50			83055		1.50	
	82670		25.00			83060		3.00	
	82671		41.00			83065		3.00	
	82672		25.00			83068		3.00	
	82677		28.00			83069		3.00	
	82679		25.00			83070		6.00	
	82690		25.00			83071		10.00	
	82693		12.50			83088		40.00	
	82696		22.00			83150		12.00	
	82705		.60			83491		12.60	
	82710		7.80			83497		6.00	
	82715		7.80			83498		30.50	
	82725		15.50			83499		30.50	
N	82728		16.00			83500		34.00	
	82731		71.20			83505		40.00	
	82735		24.00			83518		8.00	
	82742		29.50			83519		15.00	
	82746		10.50			83520		S.C.C.	
	82747		18.00			83525		12.00	
	82757		25.00			83527		22.00	
	82759		11.50			83528		20.00	
	82760		15.00		A	83540		4.50	
	82775		30.00		A	83550		7.20	
	82776		8.90			83570		6.00	
	82784		11.30			83582		6.00	
	82785		16.00			83586		7.50	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp
	83593		6.00			84127		15.00	
	83605		15.00		A	84132		3.90	
A	83615		4.20			84133		3.90	
	83625		9.00			84134		20.00	
	83632		16.00			84135		12.00	
	83633		6.30			84138		12.00	
	83634		14.00			84140		50.00	
N	83655		9.00			84143		60.00	
	83661		10.50			84144		20.00	
	83662		5.00			84146		20.00	
	83670		2.10			84150		30.00	
	83690		4.50			84153		26.00	
	83715		7.50		A	84155		1.80	
	83717		22.00			84160		1.80	
A	83718		8.00			84165		6.00	
	83719		17.00			84181		25.00	
	83721		10.00			84182		26.00	
A	83727		17.00		N	84202		10.40	
	83735		4.50		N	84203		3.00	
	83775		5.90			84206		19.00	
	83785		35.00			84207		40.00	
	83805		26.00			84210		16.00	
	83825		8.40			84220		13.00	
	83835		10.20			84228		17.00	
	83840		4.50			84233		16.00	
	83857		12.00			84234		20.00	
	83858		22.00			84235		63.20	
	83864		13.00			84238		43.00	
	83866		15.00			84244		25.00	
	83872		3.20			84252		30.00	
	83873		25.00			84255		37.00	
	83874		12.00			84260		44.00	
	83883		S.C.C.			84270		25.00	
	83885		19.00			84275		16.00	
	83887		20.00			84285		28.80	
	83890		5.71		A	84295		3.90	
	83892		5.71			84300		3.90	
	83894		5.71			84305		16.00	
	83896		5.71			84307		16.00	
	83898		30.00			84311		7.50	
	83912		31.39			84315		3.00	
	83915		6.00			84375		29.00	
	83916		20.00			84392		7.00	
	83918		19.00			84402		38.00	
	83925		22.00			84403		32.00	
	83930		9.50			84425		32.00	
	83935		9.90			84430		3.60	
	83957		65.00			84432		13.00	
	83945		17.00			84436		6.00	
	83970		54.00			84437		6.00	
	83986		4.30			84439		10.00	
	83992		18.00			84442		12.00	
	84022		20.00			84443		24.00	
	84030		6.00			84445		27.80	
	84035		4.90			84446		19.00	
	84060		3.60			84449		30.00	
	84061		3.60		A	84450		3.00	
	84066		14.00		A	84460		3.00	
A	84075		3.60			84466		19.00	
	84078		3.60		A	84478		8.30	
	84080		3.60			84479		6.00	
N	84081		24.00			84480		15.00	
	84085		7.90			84481		15.00	
	84087		15.00			84482		15.00	
A	84100		3.00			84485		3.30	
	84105		3.00			84488		3.30	
	84106		1.80			84490		3.30	
	84110		7.50			84510		12.70	
	84119		3.00		A	84520		3.00	
	84120		7.50			84525		3.00	
	84126		37.00			84540		3.00	

Ind	HCPCS Code	Mod	Maximum Fee Allowance		Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp				Office Total Fee	\$ Prof. Comp
	84545		6.00			85347		3.00	
A	84550		3.00			85348		1.20	
	84560		3.00			85360		12.00	
	84577		6.00			85362		3.00	
	84578		.40			85366		8.00	
	84580		2.10			85370		5.00	
	84583		2.10			85378		5.00	
	84585		12.00			85379		5.00	
	84586		50.00			85384		9.60	
	84588		49.50			85385		9.60	
	84590		6.00			85390		7.00	
	84597		20.00			85400		9.00	
	84600		18.00			85410		9.00	
N	84620		16.00			85415		10.00	
	84630		16.00			85420		9.00	
	84681		22.00			85421		15.00	
	84702		11.39			85441		6.00	
	84703		3.00			85445		5.00	
	84830		3.00			85460		9.40	
	84999		S.C.C.			85475		10.00	
	85002		1.20			85520		19.00	
N	85007		2.40			85525		17.00	
	85008		1.20			85530		16.00	
	85009		1.20			85535		3.00	
	85013		1.50			85540		8.90	
N	85014		1.50			85547		10.50	
N	85018		1.20			85549		28.00	
N	85021		1.80			85555		4.80	
N	85022		3.00			85557		4.80	
N	85023		S.C.C.			85576		10.00	
N	85024		4.80			85585		1.00	
N	85025		S.C.C.		N	85590		3.00	
N	85027		4.80		N	85595		3.00	
	85029		2.75			85597		20.00	
	85030		3.25			85610		3.00	
	85031		3.00			85611		4.50	
N	85041		1.20			85612		13.00	
N	85044		3.00			85613		10.00	
	85045		4.00			85635		8.40	
N	85048		1.20			85651		1.50	
	85060		S.C.C.			85660		3.00	
	85095		S.C.C.			85670		6.60	
	85097		S.C.C.			85675		6.42	
	85102		S.C.C.			85705		7.90	
	85130		S.C.C.			85730		3.00	
	85170		.60			85732		3.00	
	85175		3.90			85810		15.00	
	85210		3.00			85999		S.C.C.	
	85220		25.00			86000		.90	
	85230		25.00			86003		20.00	
	85240		25.00			86005		5.00	
	85244		29.00			86021		9.00	
	85246		10.00			86022		9.00	
	85247		10.00			86023		15.00	
	85250		27.00			86038		7.80	
	85260		26.00			86039		15.00	
	85270		26.00			86060		3.60	
	85280		26.00			86063		1.20	
	85290		8.00			86077		S.C.C.	
	85291		7.00			86078		S.C.C.	
	85292		28.00			86079		S.C.C.	
	85293		28.00			86140		3.00	
	85300		15.00			86147		38.00	
	85301		16.00			86155		14.00	
	85302		17.00			86156		3.00	
	85303		18.00			86157		9.00	
	85305		17.00			86160		9.00	
	85306		18.00			86161		9.00	
	85335		10.00			86162		15.60	
	85337		10.00			86171		4.50	
	85345		1.80			86185		7.90	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp
	86215		18.50			86635		10.00	
	86225		13.00			86638		12.50	
	86226		15.00			86641		12.50	
	86235		25.00			86644		23.00	
	86243		15.90			86645		12.00	
	86255		7.80			86648		18.00	
	86256		12.50			86651		12.00	
	86277		16.00			86652		12.00	
	86280		5.40			86653		12.00	
	86287		10.00			86654		12.00	
	86289		15.00			86658		12.00	
	86290		18.00			86663		12.00	
	86291		15.00			86664		23.00	
	86293		12.00			86665		25.00	
	86295		12.00			86668		12.00	
	86296		10.00			86671		15.00	
	86299		12.60			86674		S.C.C.	
	86302		19.00			86677		12.00	
	86306		20.00			86682		12.00	
	86308		3.00			86684		15.00	
	86309		5.00			86687		12.00	
	86310		4.50			86688		13.00	
	86311		26.00			86689		21.20	
	86316		30.00			86692		20.00	
	86317		8.00			86694		12.80	
	86318		7.00			86695		12.80	
	86320		10.50			86698		15.00	
	86325		25.00			86701		13.00	
	86327		25.00			86702		13.00	
	86329		20.00			86703		21.00	
	86331		4.50			86710		12.00	
	86332		33.00			86713		20.00	
	86334		31.20			86717		S.C.C.	
	86337		13.71			86720		15.00	
	86340		20.00			86723		15.00	
	86341		25.00			86727		15.00	
	86343		6.00			86729		12.00	
	86344		10.86			86732		15.00	
	86353		32.00	EACH MITOGEN		86735		15.00	
	86359		40.00			86738		12.00	
	86360		55.00			86741		12.00	
	86376		6.60			86744		12.00	
	86378		26.00			86747		12.00	
	86382		20.00			86750		12.00	
	86384		10.86			86753		12.00	
	86403		8.00			86756		12.00	
	86430		1.80			86759		12.00	
	86431		4.50			86762		12.00	
	86485		S.C.C.			86765		10.00	
	86490		S.C.C.			86768		12.00	
	86510		S.C.C.			86771		12.00	
	86580		S.C.C.			86774		5.40	
	86585		S.C.C.			86777		12.00	
	86586		S.C.C.			86778		15.00	
	86588		13.20			86781		12.00	
	86590		8.00			86784		8.00	
	86592		1.50			86787		12.60	
	86593		3.00			86790		S.C.C.	
	86602		10.00			86793		8.00	
	86603		10.00			86800		13.00	
	86606		10.00			86805		22.00	
	86609		10.00			86806		22.00	
	86612		10.00			86807		55.00	
	86615		10.00			86808		39.00	
	86618		25.00			86812		12.60	
	86619		10.00			86813		19.00	
	86622		8.00			86816		19.00	
	86625		10.00			86817		19.00	
	86628		10.00			86821		68.00	
	86631		10.00			86822		50.00	
	86632		15.00			86849		S.C.C.	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp
	86850		4.20			87174		10.00	
	86860		4.20			87175		15.00	
	86870		9.00			87176		6.40	
	86880		5.00			87177		5.10	
	86885		6.80			87178		24.00	
	86886		5.00			87179		24.00	
	86890		75.00			87181		5.80	
	86891		75.00		N	87184		9.00	
	86900		2.00			87186		13.00	
	86901		2.00			87187		13.00	
	86903		11.70			87188		6.00	
	86904		11.70			87190		.60	
	86905		3.00			87192		.60	
	86906		2.00			87197		15.00	
	86910		12.60			87205		4.20	
	86911		5.00			87206		4.20	
	86915		67.50			87207		3.00	
	86920		12.00			87208		5.10	
	86921		12.00			87210		2.40	
	86922		12.00			87211		5.10	
	86940		9.50			87220		2.40	
	86941		12.50			87230		27.00	
	86945		S.C.C.			87250		28.00	
	86950		S.C.C.			87252		29.50	
	86965		S.C.C.			87253		6.00	
	86970		S.C.C.			87270		10.00	
	86971		S.C.C.			87274		12.80	
	86972		S.C.C.			87320		12.50	
	86975		S.C.C.			87490		20.00	
	86976		S.C.C.			87491		38.00	
	86977		S.C.C.			87590		25.00	
	86978		S.C.C.			87591		38.00	
	86985		S.C.C.			87620		25.00	
	86999		S.C.C.			87621		38.00	
	87001		9.00			87999		S.C.C.	
	87003		15.00			88104		S.C.C.	7.00
	87015		5.10			88106		S.C.C.	7.00
N	87040		9.00			88107		S.C.C.	7.00
N	87045		9.00			88108		S.C.C.	7.00
N	87060		9.00			88125		S.C.C.	
N	87070		9.00			88130		9.65	7.00
	87072		6.00			88140		4.20	3.00
	87075		9.00			88141		6.00	
	87076		6.00			88142		18.00	
	87081		9.00			88143		18.00	
	87082		4.00			88144		18.00	
	87083		4.00			88145		18.00	
	87084		3.00			88147		13.48	
	87085		4.00			88148		13.48	
	87086		6.00			88150		6.00	
	87087		2.70			88151		6.00	
	87088		2.70			88152		6.00	
	87101		8.00			88153		6.00	
	87102		8.00			88154		6.00	
	87103		8.00		N	88155		6.00	
	87106		8.00			88156		6.00	
	87109		14.00			88157		6.00	
	87110		15.00			88160		S.C.C.	
	87116		6.00			88161		S.C.C.	7.00
	87117		9.00			88162		S.C.C.	
	87118		12.00			88164		6.00	
	87140		3.00			88165		6.00	
	87143		3.00			88166		6.00	
	87145		3.00			88167		6.00	
	87147		3.00			88170		S.C.C.	
	87151		3.00			88171		S.C.C.	
	87155		3.00			88172		S.C.C.	
	87158		3.00			88173		S.C.C.	
	87163		12.00			88180		S.C.C.	
	87164		6.00			88182		300.00	
	87166		6.00			88199		S.C.C.	

Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp
	88230		90.00	
	88233		90.00	
	88235		90.00	
	88237		90.00	
	88239		90.00	
	88245		184.00	
	88248		230.00	
	88250		184.00	
	88262		184.00	
	88263		184.00	
	88267		230.00	
	88280		37.00	
	88283		46.00	
	88285		2.00	
	88289		40.00	
	88300		S.C.C.	7.00
	88302		S.C.C.	15.00
	88304		S.C.C.	19.00
	88305		S.C.C.	30.00
	88307		S.C.C.	44.00
	88309		S.C.C.	66.00
	88311		S.C.C.	
	88312		S.C.C.	8.00
	88313		S.C.C.	5.00
	88314		S.C.C.	7.00
	88318		S.C.C.	
	88319		S.C.C.	
	88321		S.C.C.	
	88323		S.C.C.	
	88325		S.C.C.	
	88329		S.C.C.	
	88331		S.C.C.	41.00
	88332		S.C.C.	
	88342		S.C.C.	7.00
	88346		40.00	7.00
	88347		45.00	7.00
N	88348		184.00	151.00
N	88349		S.C.C.	151.00
	88355		S.C.C.	31.50
	88356		S.C.C.	31.50
	88358		S.C.C.	31.50
	88362		S.C.C.	31.50
	88365		47.25	15.75
	88371		S.C.C.	
	88372		S.C.C.	
	88399		S.C.C.	
	89050		0.90	
	89051		0.90	
	89060		8.50	
	89100		S.C.C.	
	89105		S.C.C.	
	89125		0.60	
	89130		S.C.C.	
	89132		S.C.C.	
	89135		S.C.C.	
	89136		S.C.C.	
	89140		S.C.C.	
	89141		S.C.C.	
	89160		2.10	
	89190		2.20	
	89300		2.40	
	89310		4.80	
	89320		3.00	
	89325		13.00	
F	89329		31.00	
F	89330		8.00	
	89350		S.C.C.	
	89355		S.C.C.	
N	89360		S.C.C.	
	89399		S.C.C.	

Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp
L	G0001		1.80	
L	P9610		1.80	
L	P9615		1.80	
L	Q0111		2.40	
L	Q0112		2.40	
L	Q0113		5.10	
L	Q0114		9.60	
L	Q0115		12.33	
L	Q0116		2.00	
LN	W8200		2.00	
L	W8260		33.00	
L	W8265		33.00	
L	W8730		11.00	
L	W8900		10.00	
L	W8920		1.80	
L	W8925		.60	

Amended by R.2002 d.323, effective October 7, 2002.
 See: 34 N.J.R. 959(a), 34 N.J.R. 3524(a).
 Added HCPCS Code 82731 and its corresponding Office Total Fee.
 Amended by R.2003 d.15, effective January 6, 2003.
 See: 34 N.J.R. 2676(a), 35 N.J.R. 230(c).
 Updated the table of HCPCS procedure codes.

10:52-10.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT)

PATHOLOGY/LABORATORY				Maximum Fee Allowance
Ind	Code	Mod	Procedure Description	Fee
	G0001		Routine Venipuncture	\$ 1.80
			QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	
	P9610		Catheterization for collection of (urine) specimen(s), single patient	1.80
			QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	
	P9615		Catheterization for collection of (urine) specimen(s), (multiple) patients	1.80
			QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	
	Q0111		Wet mount, including preparations of vaginal, cervical or skin specimens	2.40
	Q0112		All potassium hydroxide (KOH) preparations	2.40
	Q0113		Pinworm examination	5.10
	Q0114		Fern test	9.60
	Q0115		Post-coital direct, qualitative examinations of vaginal or cervical mucous	12.33

HCPCS Ind Code Mod	Procedure Description	Maximum Fee Allowance
Q0116	Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurements and read-out	2.00
N W8200	Glucose, serum (separate tube, grey top) QUALIFIER: Submitted on same claim, and performed on same date as chemistry profiles	2.00
W8260	Haldol (haloperidol) serum, confirmation test	33.00
W8265	Serentil, serum mesoridazine, quantitative, confirmation test	33.00
W8730	Gonozyyme, Gonococcal antigen	11.00

Amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
In the table, deleted a reference to home bound, nursing and SNF patients in P9610, and deleted W8900, W8920 and W8925.

**10:52-10.4 Pathology and Laboratory HCPCS Codes—
Qualifiers**

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Chemistry Automated, Multichannel Tests

Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting. Laboratory chemistry tests performed on your automated equipment in addition to laboratory chemistry tests listed must be billed as 80002-80019 as part of the automated multichannel test listing.

- Acid—Phosphatase
- Albumin
- Alkaline Phosphatase
- (ALT, SGPT) Aspartate Aminotranferase

- (AST, SGOT) Aspartate Aminotranferase
- Amylase
- Bilirubin, Total
- Bilirubin, Direct
- Blood Urea Nitrogen (BUN)
- Calcium
- Carbon Dioxide (CO2)
- Chlorides (Cl)
- Cholesterol
- Creatine Kinase (CK, CPK)
- Creatinine
- Gamma Glutamyl Transpeptidase (GGTP)
- Glucose (Sugar)
- Iron
- Iron Binding Capacity
- Lactic Dehydrogenase (LD)
- Lipoprotein (HDL Cholesterol)
- Magnesium
- Phosphorus
- Potassium (K)
- Protein, Total
- Sodium (NA)
- Triglycerides
- Uric Acid

NOTE 1: If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded \$5.00, the maximum reimbursement will not be more than \$5.00: 82040, 82150, 82250, 82251, 82310, 82374, 82435, 82465, 82550, 82565, 82947, 82977, 83540, 83550, 83615, 83718, 83735, 84060, 84075, 84100, 84132, 84155, 84295, 84450, 84460, 84478, 84520, 84550.

NOTE 2: The following calculations and ratios are not eligible for separate or additional reimbursement. Mathematical calculations listed below are not reimbursable:

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

NOTE 3: Any additional automated multichannel chemistry tests performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019 will not be reimbursed at the current allowable fee for each added test when performed on automated multichannel equipment.

NOTE 4: Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006,

80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional \$2.00.

2. Codes 80050, 80055, 80058, 80059, 80061, 80072, 80090, 80091, 80092. The panels listed must include the laboratory tests assigned by the CPT as the components of the panel. The tests listed with each of the panels identify the defined components of that panel. If any laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid or NJ KidCare fee-for-service program more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

NOTE 1: Code 80091—Thyroid panel

Reimbursement not eligible for 84439 when billed in conjunction with 80091 on same day.

NOTE 2: Code 80092—Thyroid panel with TSH

Code 84443—TSH will not be paid a separate reimbursement when performed in conjunction with 80091 or 80092.

3. Codes 82487, 82488, and 82489—Chromatography—must list substance (compound) tested for in block 34 (REMARKS) of the claim form.

4. Code 82728—Ferritin

When the procedure for ferritin is performed in combination with Vitamin B12 or Folate or any of the chemistry analytes listed on codes 80002-80019 the maximum reimbursable fee for code 82728 is \$5.00.

5. Code 84081—Phosphatidylglycerol—test done on newborn or amniotic fluid to determine fetal lung maturity.

6. Code 84202—Protoporphyrin, RBC; quantitative—Utilize only for testing of anemia. Utilize code 84203—Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will no longer be reimbursed when billed in conjunction with code 83655—Blood lead determination (quantitative).

7. Code 84620—Xylose absorption tests, blood and/or urine (D-xylose tolerance test), includes serum & urine levels, up to 5 hourly specimens.

8. Codes 85023 and 85025—Hematology

NOTE: For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a hematocrit, hemoglobin determination, RBC count, RBC indices, WBC count and differential WBC count (See codes 85021 and 85022), for a platelet count with a CBC (see codes 85023-85025).

Hematology codes 85014, 85018, 85041 and 85048 may not be billed in conjunction with codes for blood

count with hemogram (85021, 85022, 85023, 85024, 85025, and 85027).

The code for manual differential WBC count (85007) may not be billed in conjunction with codes 85021, 85022, 85023, 85024, 85025, and 85027.

Codes for platelet count (85590 and 85595) may not be billed in conjunction with codes 985023-85027.

Code 85044 may be billed in conjunction with codes 85023 and 85025, when a complete hemogram is ordered.

9. Codes 87040, 87045, 87060, 87070, 87184—Cultures

NOTE: These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture; (87081 and 87082).

10. Code 88155—pap smear

NOTE: Obtaining specimen not a separate eligible service.

11. Code 88348 and 89349—Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

NOTE: For reimbursement purposes, the Medicaid and NJ KidCare fee-for-service programs will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, i.e., gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

12. Code 89360—Sweat (without iontophoresis) test

NOTE: Reimbursement not eligible for qualitative tests. For reimbursement purposes, 84295 will not be reimbursed at any additional charge. Do not bill 84295 in conjunction 89360.

13. Code 36415—Utilize this code only for finger/heel/ear stick for collection of specimen(s). This service is reimbursable in the physician office laboratory (POL) when the specimen is referred out to an independent clinical laboratory for testing. Finger/heel/ear stick is not reimbursable when billed by the independent clinical laboratory.

NOTE: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.

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), inserted references to NJ KidCare fee-for-service programs in 2 and 11, and substituted a reference to CPT for a reference to CPT-4 in 2.

10:52-10.5 Pathology and Laboratory HCPCS Codes—Modifiers

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid and NJ KidCare fee-for-service programs' recognized modifier codes are:

Modifier Code	Description
22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. A report may also be appropriate.
26	Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.

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), inserted a reference to NJ KidCare fee-for-service programs.

SUBCHAPTER 11. CHARITY CARE

10:52-11.1 Charity care audit functions

(a) The Department of Health and Senior Services shall conduct an audit of acute care hospitals' charity care reported as written-off each calendar year. The Department of Health and Senior Services shall audit charity care at least once, but no more than six times each calendar year.

(b) The Department of Health and Senior Services shall report to the Division of Medical Assistance and Health Services on charity care. This report shall include any adjustments made pursuant to N.J.A.C. 10:52-11.14 or approvals made pursuant to N.J.A.C. 10:52-11.8(c) and (d).

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 "report to the Division of Medical Assistance and Health Services" for "make a monthly report to the Essential Health Services Commission" in the first sentence, and changed N.J.A.C. references in the second sentence.

10:52-11.2 Sampling methodology

(a) The Department of Health and Senior Services shall audit charity care claims based on a sample which will be developed from the charity claims submitted for pricing as described in N.J.A.C. 10:52-12.2.

(b) The Department of Health and Senior Services shall require hospitals to make a small number of additional charity care accounts available upon audit.

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

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

Rewrote (a); and deleted a former (c).

10:52-11.3 Charity care write off amount

(a) The Department of Health and Senior Services shall value charity care claims at the Medicaid rate. The Medicaid rate, for purposes of valuing a given charity care claim, shall be based on the New Jersey Medicaid program's pricing and program policies pursuant to N.J.A.C. 10:52-12.1 and 12.2. For write-off and billing purposes, the hospital shall use the following procedures:

1. Charity Care Write Off Amount equals Charity Care Eligibility Percentage, as determined by N.J.A.C. 10:52-11.8(b) and (c) multiplied by the Medicaid payment rate.

2. In the event that there is a partial payment from a third party, the charity care write-off amount is determined as follows: Charity Care Write Off Amount equals Medicaid payment rate minus third party payment multiplied by Charity Care Eligibility Percentage. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to all Federal disproportionate share rules, including the Omnibus Budget Reconciliation Act of 1993, Section 13621.

3. If the third party payment is greater than the Medicaid payment rate, the charity care write-off amount shall be listed as zero.

(b) Applicants eligible for charity care at 100 percent shall not be billed. Any difference between hospital charges and the Medicaid rate shall be recorded as a contractual allowance.

(c) Applicants eligible for charity care at less than 100 percent shall be billed as follows:

1. Applicant Responsibility equals 100 percent minus Charity Care Eligibility Percentage multiplied by Hospital Charges minus any third party payment.

2. Contractual allowance equals Hospital Charges minus any third party payment minus Charity Care Write Off plus Applicant Responsibility.

(d) The Department of Health and Senior Services will calculate the cost of charity care services at the rate that would have been paid by the New Jersey Medicaid program.

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)1, changed N.J.A.C. reference; and in (d), substituted a reference to the Department of Health and Senior Services for a reference to the Essential Health Services Commission.

Amended by R.2000 d.299, effective July 17, 2000.

See: 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

In (a), rewrote the introductory paragraph, and changed N.J.A.C. reference in 1.

10:52-11.4 Differing documentation requirements if patient admitted through emergency room

N.J.A.C. 10:52-11.5 through 11.10 govern documentation requirements for all charity care applications except those for patients admitted through the hospital's emergency room. Documentation requirements for applications of patients admitted through the emergency room are governed by N.J.A.C. 10:52-11.16.

New Rule, R.2000 d.299, effective July 17, 2000.

See 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

Former N.J.A.C. 10:52-11.4, Charity care screening and documentation requirements, recodified to N.J.A.C. 10:52-11.5.

10:52-11.5 Charity care screening and documentation requirements

(a) The hospital shall provide all patients with an individual written notice of the availability of charity care and Medicaid or NJ KidCare, in a form provided by the Department of Health and Senior Services, at the time of service, but no later than the issuance of the first billing statement to the patient.

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this subchapter. The applicant's financial file for audit shall contain the completed charity care application in a format approved by the Department of Health and Senior Services, as well as the supporting documentation which led to the determination of eligibility. For purposes of the audit, the hospital shall include in or with the file all other information necessary to demonstrate compliance with any of the audit steps.

(c) The hospital shall ask the applicant if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers compensation policy. If the applicant claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified, or the reason why the coverage

could not be verified. Verification of insurance shall include the hospital contacting the identified third party insurer. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(d) If the applicant is uninsured, or the applicant's health insurance is unlikely to pay the bill in full (based on hospital staff's previous experience with the insurer), and the applicant has not paid at the time of service any amounts likely to be remaining, the hospital shall make an initial determination for eligibility for any medical assistance programs available. The hospital shall refer the applicant to the appropriate medical assistance program and shall advise the medical assistance office of the applicant's possible eligibility. The applicant's financial file for audit shall indicate either that the applicant declined to be screened for medical assistance; that the applicant was screened but was determined ineligible; or that the applicant was screened and referred to the medical assistance program for possible eligibility. If the hospital does not screen the applicant for medical assistance, the record shall indicate the reason(s) why the applicant was not screened and the efforts the hospital made to obtain the screening. If an applicant affirmatively declines to be screened or is referred to a medical assistance program and does not return with an appropriate determination, the hospital will use the following procedures:

1. If the applicant affirmatively declines to be screened, or does not complete the medical assistance application process within three months after the date of service, or files an application after the application deadline, but is otherwise documented as eligible for charity care, the hospital:

- i. May bill the applicant, consistent with the manner applied to other patients;
- ii. Shall report the Medicaid value amount as charity care; and
- iii. Shall report any amounts collected from the applicant or any third party as a charity care recovery.

2. If the hospital has not received a response to the medical assistance application from the county board of social services or other medical assistance office within seven months of receipt of a complete application, the hospital shall approve the applicant's charity care application if the applicant meets all other charity care criteria. Should medical assistance be approved following the hospital's charity care approval, the hospital shall report the amounts collected from the medical assistance program as a charity care recovery and issue a redetermination that states that because the applicant is eligible for medical assistance, he or she is no longer eligible for charity care.

3. If the hospital does not inform the applicant of medical assistance by the individual written notice required in (a) above or does not refer an applicant who could reasonably be considered eligible for a medical assistance program within three months of the date of service, the hospital shall record the applicant's bill as a courtesy adjustment and shall not bill or otherwise attempt to collect from the applicant or the Charity Care Program.

(e) Hospitals shall make arrangements for reimbursement for services from private sources, and Federal, state and local government third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing the services to charity care except in the situations described in (h) and (i) below. The hospital shall, as part of this obligation, pursue reimbursement for the uncollected copayments and deductibles of indigent participants in Title XVIII of the Social Security Act (Medicare). Hospitals shall report any amounts collected from any third party as a charity care recovery. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(f) An applicant who is responsible for complying with his or her insurer's pre-certification requirements (the specific steps with which the insured must comply in order to have the services reimbursed) shall not be determined to be eligible for charity care, if the bill was unpaid because he or she failed to comply with these requirements. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(g) An applicant who is determined to be eligible for, and is accepted into, the HealthStart Program shall not be deemed eligible for charity care for services which are covered under this program. Beginning July 1, 1995, charity care availability shall be subject to Federal disproportionate share rules.

(h) Applicants who are eligible for reimbursement under the Violent Crimes Compensation Program shall be screened for eligibility for charity care before referral to the Violent Crimes Compensation Program (see N.J.A.C. 13:75). If the applicant is not eligible for 100 percent coverage under charity care, the charges which are not eligible for coverage under charity care shall be referred to the Violent Crimes Compensation Program. The hospital shall request the applicant to submit a copy of his or her charity care determination form to the Violent Crimes Compensation Board.

(i) Applicants who are eligible for reimbursement under the Catastrophic Illness in Children Relief Fund shall be screened for eligibility for charity care before referral to this Fund. If the applicant is not eligible for 100 percent coverage under charity care, the applicant shall be referred to the Catastrophic Illness in Children Relief Fund (see N.J.A.C. 10:155) for the uncovered portion of the claims.

(b) An applicant who willfully presents false information will be liable for all hospital charges and subject to civil penalties pursuant to N.J.S.A. 26:2H-18.63.

Recodified from 10:52-11.11 by R.2000 d.299, effective July 17, 2000.
See: 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

Former N.J.A.C. 10:52-11.12, Application and determination, recodified to N.J.A.C. 10:52-11.13.

10:52-11.13 Application and determination

(a) The Department of Health and Senior Services shall provide acute care hospitals with a standardized application and determination form. This application and determination form shall be used by all acute care hospitals for the Charity Care Program. The application form shall advise patients of the penalties for providing false information on a charity care application.

(b) An applicant or responsible party may request a hospital to make a determination for charity care or reduced charge charity care at any time up to one year from the date of service. A hospital may, at its discretion, accept applications after one year from the date of service. The hospital shall make the charity care determination and notify the applicant in writing, as soon as possible, but no later than 10 working days from the day the applicant submits a completed application. If the application does not include sufficient documentation to make the determination, the hospital shall notify the applicant, in writing, as soon as possible, but no later than 10 working days from the day the applicant submits an incomplete application. The applicant shall be permitted to supply additional documentation at any time up to one year after the date of service.

(c) A determination that an applicant is eligible shall indicate:

1. The date on which the eligibility determination was made;
2. The date on which hospital services were requested;
3. The date on which the services were or will be provided to the applicant;
4. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;
5. The applicant's family size, income and eligibility computation;
6. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old; and
7. The name and telephone number of a person a hospital can contact to verify eligibility.

(d) The hospital shall provide each applicant who requests charity care and is denied it, in whole or part, with a written and dated statement of the reasons for the denial, including information required in (c) above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. Where a denial is based on a presumption that the applicant is eligible for, but not enrolled in, Medicaid or NJ KidCare, the information upon which the denial is based must be documented.

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

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

In (a), substituted a reference to the Department of Health and Senior Services for a reference to the Essential Health Services Commission; in (c)7, deleted N.J.A.C. reference; and in (d), inserted a reference to NJ KidCare.

Recodified from 10:52-11.12 by R.2000 d.299, effective July 17, 2000.

See: 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

Former N.J.A.C. 10:52-11.13, Collection procedures and prohibited action, recodified to N.J.A.C. 10:52-11.14.

10:52-11.14 Collection procedures and prohibited action

Persons determined to be eligible for charity care shall not receive a bill for services or be subject to collection procedures. Persons determined to be eligible for reduced charge charity care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge charity care.

Recodified from 10:52-11.13 by R.2000 d.299, effective July 17, 2000.

See: 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

Former N.J.A.C. 10:52-11.14, Adjustment methodology, recodified to N.J.A.C. 10:52-11.15.

10:52-11.15 Adjustment methodology

(a) For a listing adjustment, the charity care write off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid program. To the extent that charity care write off amounts are overstated, the hospital's listing total will be reduced by the amount of the overstatement.

(b) For an alternative documentation adjustment, a ratio shall be developed using sample dollars with alternative documentation as a percentage of total sample dollars. If this ratio is less than or equal to .10, there shall be no adjustment. If this ratio is greater than .10, the ratio shall be reduced by .10 and then multiplied by hospital charity care at the Medicaid rate. This amount shall be subtracted from hospital charity care at the Medicaid rate. The result shall be used in the compliance adjustment calculation in (c) below.

(c) For a compliance adjustment, each file reviewed must pass the compliance steps in N.J.A.C. 10:52-11.5 through 11.11. Failure in any one step fails the file and associated sample dollars. A failure rate (failed dollars divided by the total dollars sampled) that meets or exceeds 10 percent shall require an adjustment to the hospital's charity care listing total, based on unit dollar sampling.

(d) The hospital's charity care total adjusted for (a), (b) and (c) above will constitute the hospital's audited charity care amount.

(e) A hospital which disagrees with the audit findings may request a review of auditor judgment with representatives from the Department of Health and Senior Services within 15 days of the date that the Department of Health and Senior Services' staff or Department of Health and Senior Services' audit subcontractor finishes their review of the hospital's charity care files and provides the hospital with a copy of the audit results.

(f) A hospital which disagrees with the audit findings may request an administrative hearing, which shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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

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

In (c), changed N.J.A.C. reference.

Recodified from 10:52-11.14 and amended by R.2000 d.299, effective July 17, 2000.

See: 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

In (c), changed N.J.A.C. reference.

10:52-11.16 Charity care applications of patients admitted through emergency room

(a) If a charity care applicant is admitted through the hospital's emergency room, the requirements set forth in this section shall apply.

1. The hospital shall notify the patient, orally and by providing a copy of the individual written notice referenced in N.J.A.C. 10:52-11.5(a), of the availability of charity care. This notice shall be given prior to the patient's discharge from the hospital.

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this section. The applicant's financial file for audit purposes shall contain the supporting documentation described in this section.

(c) If the applicant's medical condition permits, the hospital shall ask the applicant, prior to discharge, if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers' compensation policy. If the applicant claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified, or the reason why the coverage could not be verified. Verification of insurance shall include the hospital contacting the identified third party insurer. Charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(d) If the applicant's medical condition permits, the hospital shall also, prior to the applicant's discharge, request the following information, which shall be recorded by the hospital on a form approved by the Department of Health and Senior Services:

1. The applicant's name;
2. The address of the applicant's residence;
3. Whether the applicant intends to remain a resident of New Jersey (assuming current residence in New Jersey);
4. The applicant's home telephone number, if any;
5. Whether the applicant is employed and, if so, the employer's name and address;
6. Applicant's best estimate of annual income, including sources of income and income from each source; and
7. Whether the applicant has an account with a bank and, if so, the name and location of the bank.

(e) If the hospital is able to obtain the information listed in (d) above, the hospital shall, prior to the applicant's discharge, ask the applicant to read the form on which the information has been recorded, and verify the information's accuracy by signing the form. The form shall also include a statement authorizing the hospital to contact any person or entity listed on the form in order to obtain and/or verify information relating to the charity care application.

(f) The hospital shall verify that the applicant is not enrolled in a medical assistance program.

(g) If the applicant is determined to be uninsured and not enrolled in a medical assistance program, and the hospital has been able to obtain the information and applicant's signature described in (d) and (e) above, then the hospital shall process the charity care application based on the information obtained. (If the information and applicant's signature described in (d) and (e) above cannot be obtained by the hospital, in whole or in part, then the provisions of (h) below shall apply.) The applicant's charity care eligibility shall be determined based on the following requirements:

1. The applicant's self-identification shall be acceptable to establish identity;
2. The applicant shall be a resident of New Jersey at the time of service, and shall have the intent to remain in the State as demonstrated by the applicant's statement of intent. The hospital shall verify, by telephone or visit, that the applicant can be contacted at the address provided; if the address is in the State, this shall establish New Jersey residency for this purpose. The method of verification shall be documented in the financial file for audit purposes;

(h) If the applicant is determined to be uninsured and not enrolled in a medical assistance program, and if the hospital was unable to obtain the information and applicant signature described in (d) and (e) above, then the hospital shall make the following efforts to determine whether the applicant is eligible for charity care. The hospital shall:

1. Make at least two attempts to contact the patient by phone, if a phone number is available, to try to schedule an in-person interview to obtain information relevant to the application. If such an interview can be arranged, the hospital shall obtain the relevant information and process the application based on that information. If such an interview cannot be arranged, this shall be documented in the financial file for audit purposes;

2. Visit the address given by the applicant, or otherwise obtained, and attempt to verify that the applicant lives there. If the applicant is homeless and has not provided the address of a shelter or other temporary residence, this requirement shall not apply. This shall be achieved by direct contact with the applicant, if possible, or by asking persons at the address, neighbors, or by observing the surroundings (for example, name on mailbox). The results of this attempt shall be documented in the financial file for audit purposes. If the hospital is able to achieve direct contact with the applicant, the hospital shall try to conduct or schedule an in-person interview to obtain information relevant to the application. If such an interview can be arranged, the hospital shall obtain the relevant information and process the application based on that information. If such an interview cannot be arranged, this shall be documented in the financial file for audit purposes; and

3. Attempt to determine the applicant's income and assets. This includes observing the nature of the applicant's housing, to determine whether there are any indications that the applicant would not likely be eligible for charity care and obtaining information from persons at the applicant's address or from neighbors regarding the applicant's employment or other means of support. The results of these attempts shall be documented in the financial file for audit purposes.

(i) If the applicant is determined to be eligible for charity care under (g) above or, in the alternative, if the hospital has completed and documented the efforts set forth in (h) above, then the hospital may write off to charity care the claim(s) arising from the admission, subject to the following limitation: permitted calendar year 1999 claims can be submitted for consideration for the State fiscal year 2001 charity care subsidy pursuant to this section, in a manner to be specified by the Department of Health and Senior Services, only until August 16, 2000 notwithstanding any other regulatory provision. Permitted calendar year 1999 claims that are submitted after August 16, 2000, but before the end of calendar year 2000, shall be considered for the State fiscal year 2002 charity care subsidy. Permitted claims from the period January 1, 2000 through July 17, 2000 are not

subject to the above-referenced August 16, 2000 submission limitation, and shall be considered for the State fiscal year 2002 charity care subsidy. Notwithstanding any other provision of this subchapter, if an applicant is determined to be eligible for charity care under (g) above or, in the alternative, if the hospital has completed and documented the efforts set forth in (h) above, and the patient is subsequently transferred to, and admitted at, another hospital, then the hospital admitting the transferred patient may rely upon the charity care determination of the transferring hospital, and write off to charity care the claim(s) arising from the transfer admission, subject to the following limitation: permitted calendar year 1999 claims can be submitted for consideration for the State fiscal year 2001 charity care subsidy pursuant to this section, in a manner to be specified by the Department of Health and Senior Services, only until August 16, 2000, notwithstanding any other regulatory provision. Permitted calendar year 1999 claims that are submitted after August 16, 2000, but before the end of calendar year 2000 shall be considered for the State fiscal year 2002 charity care subsidy. Permitted claims from the period January 1, 2000 through July 17, 2000 are not subject to the above-referenced August 16, 2000 submission limitation, and shall be considered for the State fiscal year 2002 charity care subsidy. See N.J.A.C. 10:52-11.3 regarding the charity care write off amount. The applicant shall not be deemed to be eligible for charity care for future services based on this determination, but would, instead, be required to meet the requirements set forth at N.J.A.C. 10:52-11.5 through 11.10 and 11.12 at the time future services were rendered, unless the applicant is admitted through the emergency room in the future, in which case N.J.A.C. 10:52-10.16 would apply.

(j) Claims that are written off to charity care under (i) above shall not be included when determining the "alternative documentation" adjustment. See N.J.A.C. 10:52-11.11 and 11.15.

New Rule, R.2000 d.299, effective July 17, 2000.
See: 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

10:52-12.1 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund

(a) This section sets forth the requirements of the New Jersey State Department of Health and Senior Services that the provider shall adhere to when submitting a claim and requesting pricing for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund for hospital services.

(b) In addition to information in this section about submitting claims for pricing of outpatient and inpatient charity care claims, a Fiscal Agent Billing Supplement is included following this chapter. The supplement includes information regarding the following items: information for the proper completion and submission of claim forms; the procedure to follow when claims are rejected and returned to the provider by the Fiscal Agent during the adjudication process; third party liability verification; examples of timely submission of claims; electronic media claims (EMC) submission; information regarding Remittance Advice Statements for pricing of claims, and adjustments of Medicare; the procedure to follow when a claim is priced in error (void); the procedure for inquiries about claims; the procedure for ordering forms; information about provider services; and item by item instructions for completing the claim form and other forms.

1. The Fiscal Agent Billing Supplement is not published in the New Jersey Administrative Code (N.J.A.C.) but is referenced as an Appendix to this chapter and is, thus, not a legal description of the charity care program rules. Should there be any conflict between the Fiscal Agent Billing Supplement and the pertinent laws or rules governing the charity care program, the charity care program rules take precedence.

(c) A claim, as it applies only to charity care, is defined as a request for the New Jersey charity care pricing, which properly identifies the hospital, the services rendered, the recipient of the services, the date of the services, the charge for the services, and any other data required by the State.

1. A charity care pricing claim shall be submitted by an approved method of automated data exchange. In order for a charity care program claim to be considered for pricing, appropriate information shall be included on the claim.

(d) The State of New Jersey uses a fiscal agent for the pricing of charity care claims.

1. The charity care statement is the provider's account statement for all charity care claims entered into the charity care claims pricing system. Charity care claims shall be priced monthly and provider charity care statements shall be processed once each month.

2. The charity care statement is the major vehicle for communicating to the provider the status of all charity care claims received by the fiscal agent. All providers' claims are processed and supporting records are updated during each pricing cycle. Statements are generated as a result of a pricing cycle. All charity care claims processed (entered into the system) fall into one of two classifications:

i. The first classification is a priced claim. A charity care claim which is correctly completed for a covered service provided to a charity care recipient by an approved provider will be priced. The status of the claim shall appear on the claim status page, or pages, along with the status of all other claims which are being priced in that cycle. If the amount differs from the billed charges, an explanation may appear on the statement.

ii. The second classification is a denied (unpriced) claim. Reasons for denial (non-pricing) of a charity care claim shall be provided on the statement in the form of a code.

(1) Messages explaining all codes shall be printed on a separate page.

(e) A unique 13 digit internal control number (ICN) is assigned to each charity care program claim received by the fiscal agent. The ICN is reflected on the charity care statement for the charity care claims. The ICN can be used to track the status of a claim. For more information about the ICN, see the Fiscal Agent Billing Supplement following this chapter.

10:52-12.2 Basis of pricing for charity care claims

(a) All hospital outpatient and inpatient charity care claims shall be priced based on the New Jersey Medicaid program's pricing and program policies for hospital outpatient and inpatient hospital services. (See this chapter, and, specifically, N.J.A.C. 10:52-1.6, Covered services (inpatient and outpatient services) and N.J.A.C. 10:52-4, Basis of Payment.)

1. Exception: Although the New Jersey Medicaid program reimburses dental services on a fee-for-service schedule for outpatient hospital charity care claims, dental services shall be priced based on hospital outpatient cost to charge ratio as described in N.J.A.C. 10:52-4.3. All other hospital outpatient services for charity care shall also be priced according to the Medicaid hospital outpatient methodology. (See N.J.A.C. 10:52-4.3.)

(b) All hospital outpatient and inpatient charity care claims pricing results shall be considered final and not subject to cost settlements or adjustments resulting from subsequent rate appeal changes when evaluating total charity care amounts.

Amended by R.2000 d.29, effective January 18, 2000.
31 N.J.R. 3151(a), 32 N.J.R. 276(a).
Changed N.J.A.C. reference.

SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

10:52-13.1 Disproportionate share adjustment—general eligibility

(a) A disproportionate share hospital (DSH) shall be a hospital designated as such by the Commissioner of the Department of Human Services. At a minimum, each hospital with a Medicaid inpatient hospital utilization rate that is one standard deviation above the mean Medicaid utilization rate for hospitals receiving Medicaid payments in the State, and every hospital with a low-income utilization rate above 25 percent will be treated as a disproportionate share hospital.

(b) The Commissioner of the Department of Human Services may designate additional hospitals as disproportionate share hospitals if it is determined they serve a large number of low-income mentally ill or developmentally disabled clients.

(c) The Commissioner of the Department of Human Services may make additional disproportionate share payments to facilities operating under N.J.S.A. 18A:64G-1 et seq. providing a high level of charity and uncompensated care to low-income persons and persons with special needs.

(d) The Commissioner of the Department of Human Services may also designate a hospital as eligible for additional disproportionate share payments if it is determined that the hospital provides a high percentage of care (as defined in N.J.A.C. 10:52-13.5) in proportion to total operating revenue to patients with HIV, mental illness, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse. In addition, to be designated as eligible for this additional disproportionate share payment, the facility shall have a high Charity Care plus Medicaid utilization rate (as defined in N.J.A.C. 10:52-13.5). A facility shall further demonstrate a commitment to the establishment and operation of a managed care program for the uninsured and other low-income persons.

Amended by R.1997 d.92, effective February 18, 1997.
See: N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).

Substantially amended (d).

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).

In (a), deleted the third sentence.

Recodified from 10:52-8.1 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 (d) changed N.J.A.C. references throughout, and substituted a reference to complex neonates, HIV as a secondary diagnosis and mothers with substance abuse for a reference to neonatal complexity at the end of the first sentence.

10:52-13.2 Disproportionate share hospital (DSH) payment—general

The disproportionate share adjustment shall include an adjustment amount annually determined, as to N.J.A.C. 10:52-13.4, by the Commissioner, Department of Health and Senior Services in consultation with the Commissioner, Department of Human Services and, as to N.J.A.C. 10:52-13.3, 13.5, 13.6 and 13.7 by the Commissioner, Department of Human Services based upon a determination regarding payments for charity care. The annual DSH payments shall be calculated and distributed in accordance with all applicable Federal laws and regulations.

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: 28 N.J.R. 4115(a).

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: 28 N.J.R. 4115(a), 28 N.J.R. 4805(c).

Amended by R.1997 d.92, effective February 18, 1997.

See: 28 N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

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).

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

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

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a) and amended by R.2000 d.29, effective January 18, 2000.

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

Changed N.J.A.C. references throughout.

10:52-13.3 Eligibility and disproportionate share hospital payments for hospitals operating under N.J.S.A. 18A:64G-1

For facilities operating under N.J.S.A. 18A:64G-1 et seq., the disproportionate share allocation may be increased by an amount recommended by the Office of Management and Budget which will consider the total operating cost of the facility less any third party payments, including all other Medicaid payments, as well as payments from non-State sources for services provided by the hospital during the hospital's fiscal year.

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: 28 N.J.R. 4115(a).

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: 28 N.J.R. 4115(a), 28 N.J.R. 4805(c).

Amended by R.1997 d.92, effective February 18, 1997.

See: 28 N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

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).

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

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

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a)1 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 a reference to disproportionate share allocations for a reference to disproportionate share adjustments determined by the Essential Health Services.

10:52-13.4 Eligibility for and disproportionate share hospital payments from the Charity Care Component of the Health Care Subsidy Fund

(a) The recommendation from the Department of Health and Senior Services (DHSS) shall be calculated in the following manner pursuant to N.J.S.A 26:2H-18.

1. The determination of the value of the Charity Care Component of the Health Care Subsidy Fund shall be calculated in the following manner:

i. The Department of Health and Senior Services shall use the results of the charity care audit conducted as its definition of charity care incurred by all hospitals.

ii. The New Jersey Department of Health and Senior Services shall report the results of its audit of New Jersey acute care hospital's charity care that was conducted in accordance with N.J.A.C. 10:52-11 to the Division of Medical Assistance and Health Services.

(1) For purposes of determining annual charity care costs, the criteria in N.J.A.C. 10:52-11 shall not apply to a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction pursuant to N.J.S.A. 30:4-1 et seq. A patient so found shall qualify for 100 percent charity care coverage. Hospitals with patients who qualify under this provision shall include the appropriate documentation from the court in the patient's file for audit.

(b) All charity care accounts shall be valued at the Medicaid rate as follows:

1. For inpatient accounts, the New Jersey Department of Health and Senior Services and the New Jersey Department of Human Services shall value each account at the rate Medicaid would have reimbursed hospitals for the services(s).

2. For outpatient accounts, outpatient charity care accounts written-off during the calendar year will be valued as follows: annual outpatient charity care charges multiplied by the ratio of the annual outpatient Medicaid payments to the annual outpatient Medicaid charges associated with paid claims. This Medicaid outpatient payment-to-charge ratio excludes billings for HealthStart and dental services.

3. Disproportionate share adjustments and final rate settlements for the service period shall not be taken into account for the recognition of charity care costs.

(c) For eligible hospitals, charity care subsidy amounts are determined as follows:

1. Eligible hospitals annual charity care subsidy amount is equal to charity care costs as determined by the audit and valued at Medicaid rates.

2. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase used to set Medicaid hospital rates will be used to inflate charity care costs in the current year.

3. In no instances shall payments made during a calendar year exceed the preceding years audited and Medicaid rate valued amounts inflated by TEFRA rates used in the hospital rate setting system.

4. Any overpayments which result from interim payments exceeding the audited payment levels shall be recovered by offsetting all Medicaid payments.

(d) For periods in which the data source excludes Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) in the Medicaid rate, the Medicaid rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified, for periods through State Fiscal Year 1999, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. Effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. These GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid rate adjustments. For the purpose of pricing charity care claims under this section, unless otherwise indicated, the Medicaid rate shall be defined as the Medicaid rate in effect on the date of discharge. The add-ons shall be calculated as follows:

1. The GME add-on shall be calculated as follows:

i. For charity care payments made for January 1998 through June 1998, the charity care GME add-on shall be calculated based on charity care's share of the teaching hospital's aggregate approved GME amount from Worksheet E-3 Part IV as reported on the 1996 submitted Medicare cost report. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, after desk audit. The resulting charity care GME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996, and shall be based on the percentage of charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

ii. For charity care payments made in State Fiscal Year 1999, the charity care GME add-on shall be calculated based on the charity care's share of the teaching hospital's aggregate approved GME amount from Worksheet E-3 Part IV as reported on the most recent submitted Medicare cost report as of October 1 preceding the distribution year. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, after desk audit.

iii. For charity care payments made after State Fiscal Year 1999, the charity care GME add-on shall be calculated based on the charity care share of the teaching hospital's aggregate approved GME amount from Worksheet E-3 Part IV as reported on the most recent submitted Medicare cost report as of February 1 of each year preceding the distribution year. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, after desk audit.

2. The IME add-on shall be calculated as follows:

i. For charity care payments made for January 1998 through June 1998, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the

IME formula, IME intern and resident FTEs and maintained beds shall be taken from the 1996 Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the 1996 Medicare submitted cost report. This charity care IME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996. (Charity care claims are priced at the Medicaid rate in effect when the services are rendered.) This adjustment shall be based on the percentage of inpatient charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

ii. For charity care payments made in State Fiscal Year 1999, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report as of October 1 preceding the distribution year. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

iii. For charity care payments made after State Fiscal Year 1999, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report as of February 1 of each year preceding the distribution year. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

(e) As provided in N.J.S.A. 26:2H-18.59e, the charity care subsidy shall be determined according to the following methodology:

1. The hospital-specific "documented charity care" shall be calculated from the dollar amount of charity care provided by the hospital that is submitted to the charity care fiscal intermediary and valued at the same rate paid to that hospital by the Medicaid program. A sample of the claims submitted by the hospital to the fiscal intermediary shall be subject to an audit conducted pursuant to charity care eligibility criteria. For each fiscal year, docu-

mented charity care shall be equal to the Medicaid-priced amounts of charity care claims submitted to the fiscal intermediary for the most recent calendar year, adjusted as necessary to reflect the audit results.

2. The hospital-specific "operating margin" shall be calculated using data from the three most current years' New Jersey Hospital Cost Reports and shall be equal to income from operations minus charity care subsidies divided by total operating revenue minus charity care subsidies. After calculating each hospital's operating margin, the Department shall determine the Statewide median operating margin.

3. The hospital-specific "profitability factor" shall be determined annually as follows. Those hospitals that are equal to or below the Statewide median operating margin shall be assigned a profitability factor of "1." For those hospitals that are above the Statewide median operating margin, the profitability factor shall be equal to:

$$1 - \frac{.75 \times (\text{hospital specific operating margin} - \text{Statewide median operating margin})}{\text{highest hospital specific operating margin} - \text{Statewide median operating margin}}$$

4. The hospital-specific "adjusted charity care" shall be equal to a hospital's documented charity care times its profitability factor.

5. The hospital-specific "revenue from private payers" shall be equal to the sum of the gross revenues reported to the Department in the hospital's most recently available New Jersey Hospital Cost Report for all non-governmental, or private third party payers including, but not limited to, Blue Cross and Blue Shield plans, commercial insurers and the non-governmental, or private accounts of health maintenance organizations. Gross revenue derived from governmental accounts of health maintenance organizations from the Medicare, Medicaid and NJ Family-Care (including NJ KidCare) programs, will not be included in the category of "revenue from private payers."

6. The hospital-specific "payer mix factor" shall be equal to a hospital's adjusted charity care divided by its revenue from private payers.

7. The "Statewide target payer mix factor" shall be equal to the lowest payer mix factor to which all hospitals receiving charity care subsidies can be reduced by spending all available charity care subsidy funding for that year.

8. The hospital-specific "income from operations" shall be defined by the Department of Health and Senior Services (Department) in accordance with financial reporting requirements established pursuant to N.J.A.C. 8:31B-3.3.

9. The hospital-specific "total operating revenue" shall be defined by the Department in accordance with financial reporting requirements established pursuant to N.J.A.C. 8:31B-3.3.

10. Charity care subsidy payments shall be based upon hospital-specific documented charity care.

11. If the Statewide total of adjusted charity care is less than available charity care funding, a hospital's charity care subsidy shall equal its adjusted charity care.

12. If the Statewide total of adjusted charity care is greater than available charity care funding, then the hospital-specific charity care subsidy shall be determined by allocating available charity care funds so as to equalize hospital-specific payer mix factors to the Statewide target payer mix factor. Those hospitals with a payer mix factor greater than the Statewide target payer mix factor shall be eligible to receive a subsidy sufficient to reduce their factor to that Statewide level. Those hospitals with a payer mix factor that is equal to or less than the Statewide target payer mix factor shall not be eligible to receive a subsidy.

Amended by R.1994 d.432, effective August 15, 1994.

See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).

Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).

See: 26 N.J.R. 3485(a).

Petition for Rulemaking.

See: 26 N.J.R. 3756(a).

Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.

See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).

Amended by R.1995 d.13, effective January 3, 1995.

See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).

See: 28 N.J.R. 4115(a).

Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.

See: 28 N.J.R. 4115(a), 28 N.J.R. 4805(c).

Amended by R.1997 d.92, effective February 18, 1997.

See: 28 N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).

In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.

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).

Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

Amended by R.1998 d.340, effective July 6, 1998.

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

In (a), rewrote 2 and 4, and deleted a former 6.

Recodified from 10:52-8.2(a)2 and 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).

Rewrote the section.

Amended by R.2001 d.301, effective August 20, 2001.

See: 33 N.J.R. 2062(a), 33 N.J.R. 2811(a).

Added (e).

10:52-13.5 Eligibility for and payment of Hospital Relief Subsidy Fund DSH

(a) Hospitals eligible for additional disproportionate share payments may receive an additional payment determined by the Commissioner of the Department of Human Services from the Hospital Relief Subsidy Fund. This additional payment shall be based upon the facility's percentage of clients with HIV, mental health, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse.