CHAPTER 31B

HOSPITAL FINANCING

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SUBCHAPTER 1. GENERAL PROVISIONS

8:31B–1.1 Purpose and scope

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

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

Case Notes

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

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

8:31B–1.2 Definitions

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

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

"Audited Current Cost Base" means the current cost base of the hospital, as adjusted as a result of audits conducted by the Department and/or acceptance by the Department of adjustments initiated by the hospital, in addition to the adjustments.

"Current Cost Base" means the actual costs and revenues of the hospital as identified in the Financial Elements in the reporting period, as adjusted by the Department for completeness and/or mathematical accuracy.

"Department" means the New Jersey Department of Health and Senior Services.

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

"Hospital" means a general hospital that is licensed in accordance with N.J.A.C. 8:43G or a special hospital eligible for Medicaid Disproportionate Share subsidies that is licensed in accordance with N.J.A.C. 8:43G.

"Neonate" means a newborn less than 29 days of age.

"Reporting Period" means the most recent calendar or fiscal year prior to the June 30th submission deadline for the hospital's current cost base reports.

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

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

Amended by R.1991 d.158, effective March 18, 1991.
See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
Definitions for full rate review and prospective operating adjustment added.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Definition for Preliminary Cost Base revised.
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
Inserted "Department".
Amended by R.2003 d.40, effective January 21, 2003.
See: 34 N.J.R. 2237(a), 34 N.J.R. 2549(b), 35 N.J.R. 408(a).
Added "Audited Current Cost Base", "Hospital" and "Reporting Period"; deleted "Base year", "Equalization Factor", "Labor Market Area", "Preliminary Cost Base", "Utilization Review Committee" and "Utilization Review Organization (URO)"; amended "Current Cost Base".

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

8:31B–2.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a single patient data reporting system to satisfy the health planning requirements of the Health Care Reform Act of 1992 (P.L.1992, c.160). The subchapter incorporates herein by reference the National Uniform Bill (UB–92 HCFA–1450) as the common hospital billing format for all payers. The data elements and design of the form have

been determined by the National Uniform Billing Committee (NUBC). The NUBC includes representatives of the Federal Government, major payers and hospital associations.

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

1. Satisfy Department of Health and Senior Services reporting requirements for patient level clinical and financial information;

2. Allow for common and consistent reporting of revenues for services related to patient care; and

3. Promote uniformity and accuracy of patient data reporting. Confidentiality of individual patients and physicians shall be maintained in fulfilling the above purposes.

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

8:31B–2.2 Implementation

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

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

8:31B–2.3 Billing form

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

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

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

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

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

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

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

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

(b) Billing timelines requirements are as follows:

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

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

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

Amended by R.1980 d.361, effective August 7, 1980.
See: 12 N.J.R. 392(d), 12 N.J.R. 517(b).
Amended by R.1981 d.404, effective November 2, 1981 (operative January 1, 1982).
See: 13 N.J.R. 410(a), 13 N.J.R. 756(c).
Item 41: Note substantially amended.
Amended by R.1983 d.598, effective December 19, 1983.
See: 15 N.J.R. 1325(a), 15 N.J.R. 2162(a).
022: New Jersey Blue Cross was "Other" New Jersey Blue Cross; reference to "Host Bank" deleted.
026: New Jersey Blue Cross was "Other" Blue Cross.
Amended by R.1984 d.610, effective January 7, 1985.
See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
Amended by R.1989 d.154, effective March 20, 1989.
See: 20 N.J.R. 3057(a), 21 N.J.R. 752(b).
Citation error corrected.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
DRG data items to be same as payment data.
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
Amended by R.1994 d.488, effective September 19, 1994.
See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
In (b), deleted "appropriate" preceding "data" in the second sentence of 2, and added 3.

8:31B–2.5 Health data submissions to the Department of Health and Senior Services

(a) A data intermediary shall be selected as follows:

1. A data intermediary is the data processor approved by the Department of Health and Senior Services responsible for collecting, editing, generating selected reports, and submitting the UB–92 data to the Department of Health and Senior Services.

2. A single data intermediary shall be chosen and shall be responsible for all patients regardless of payor class. In the event that it becomes necessary to approve additional data processors, the Department will promulgate an approved list of data processors.

(b) Contractual arrangements between the hospital and the data intermediary shall include the following:

1. The contractual arrangements between a hospital and its data intermediary shall include:

i. Provisions for compliance with the data submission time limits specified in N.J.A.C. 8:31B–2.4(b);

ii. Provisions for permitting delays in such submissions to the intermediary when circumstances require;

iii. Provisions for resolution of any resulting disputes.

2. Provisions must not affect the ability of the intermediary to comply with the timing requirements set forth in (g) below.

(c) The contractual arrangements shall provide for the quality control measures needed to ensure accurate and reliable data submission by the hospital.

(d) To assess the accuracy and reliability of the data provided to the Department of Health and Senior Services, the Department of Health and Senior Services shall periodically audit selected records in the hospital.

(e) Data shall be edited as follows:

1. The data received by the intermediary from the hospital must be edited prior to submission to the Department of Health and Senior Services, in accordance with the current contract between the Department and the data intermediary.

2. Problems detected by these edits shall be corrected by the Intermediary and the hospital.

3. Information required from the hospital by the Intermediary for edit correction must be provided within five working days of the request unless separate arrangements are made between the hospital and intermediary.

4. Notwithstanding (e)1 through 3 above, at such time as electronic data submission shall be formally adopted as a hospital's means of discharge data transmission, which adoption shall occur no sooner than 30 days after written notice by the Department to the hospital and the data intermediary, the hospital shall thenceforth submit information required by the data intermediary for edit correction within two working days of the request.

(f) Reports shall be produced as follows:

1. The data intermediary shall produce, for the Department of Health and Senior Services and each hospital, a set of periodic reports which will accurately represent the data submitted by each hospital, in accordance with the current contract between the Department and the data intermediary.

2. In addition, hospitals may designate an additional organization, known as a data reporter, to assist in the verification of the accuracy and reliability of the data submitted to the intermediary. The Department of Health and Senior Services shall direct the data intermediary, selected under (a) above, to release a hospital's data to the reporter only upon receipt of a current signed agreement between the hospital and the data reporter. This agreement shall be updated annually, and shall:

i. Indicate the hospital's designation of a data reporter;

ii. Provide for the protection of confidential data consistent with Department of Health and Senior Services procedures; and

iii. Allow for subsequent re-release of the data by the reporter only when the procedures, set by the Department of Health and Senior Services, have been followed.

3. These reports are to be used by the hospitals, in conjunction with any other information provided by their data collector or the Department of Health and Senior Services, to verify the accuracy and reliability of the data submitted.

4. The ultimate responsibility for the completeness and accuracy of the UB–92 data submitted to the Department of Health and Senior Services rests with the hospital.

5. Upon request of a payer, the final UB–92 information shall be provided to the payer, for its own cases, by the UB–92 Intermediary.

(g) Data shall be submitted to the Department of Health and Senior Services as follows:

1. Those data elements required to be submitted to the Department of Health and Senior Services by each hospital through the data intermediary are described in detail in the addendum to the UB–92 guidelines.

i. These required data, edited pursuant to (e) above, shall be submitted to the Department of Health and Senior Services by the data intermediary in a computer processable format and medium, specified by the current contract, within 90 days of the end of each calendar quarter.

ii. Each submission is to include the data on all patients discharged during the calendar quarter.

iii. Notwithstanding (g)1i and ii above, at such time as electronic data submission shall be formally adopted as a hospital's means of discharge data transmission, which adoption shall occur no sooner than 30 days after written notice by the Department to the hospital and the data intermediary, the data intermediary shall thenceforth submit data to the Department of Health and Senior Services for that hospital as follows:

(1) Those data elements required to be submitted to the Department of Health and Senior Services by each hospital through the data intermediary are described in detail in the addendum to the UB–92 guidelines.

(2) These required data, edited pursuant to (e) above, shall be submitted to the Department of Health and Senior Services by the data intermediary in a computer processable format and medium, specified by the current contract between the Department and the data intermediary, within 5 days of the end of each calendar month.

(3) Each submission is to include the data on all discharges billed during the previous calendar month.

2. Records not received by the Department of Health and Senior Services (including corrections of fatal errors and records with missing or incorrect information), within the time frames specified, shall be subject to a penalty of $1.00 per record per day. The Department shall provide 30 days notice of its intent to close the data base. The data base shall be closed no sooner than 90 days following the end of the calendar year and no additional cases shall be added after that time.

3. All data submitted to the Department of Health and Senior Services will be edited upon receipt by the data intermediary and any problems detected shall be corrected by the data intermediary with any necessary assistance from the hospital.

(h) All data collected by the data intermediary pursuant to this regulation are confidential in accordance with Section 1106(a) of the Federal Privacy Act of 1974 as amended by the Congressional Reports Elimination Act of 1982 (p.197–375).

(i) The intermediary(ies) shall charge the hospitals a maximum amount of $1.45 per discharge to process hospital UB–92 data.

Amended by R.1984 d.610, effective January 7, 1985.
See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
Substantially amended.
Amended by R.1991 d.158, effective March 18, 1991.
See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
No cases added to data base after closing.
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
Amended by R.1994 d.488, effective September 19, 1994.
See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
In (a)2, deleted "by each hospital" following "chosen" in the first sentence; in (d), deleted "with no attempt to tie together patient names and patient identification numbers at the Department of Health" at the end; in (e), rewrote 1, and added 4; in (f), rewrote the introductory paragraph, deleted a former 2, and recodified former 3 through 6 as 2 through 5; and rewrote (g).

8:31B–2.6 (Reserved)

SUBCHAPTER 3. FINANCIAL MONITORING AND REPORTING REGULATIONS

8:31B–3.1 Statement of purpose

The following financial monitoring and reporting rules in conjunction with Financial Elements (N.J.A.C. 8:31B–4), the Uniform Cost Reporting (N.J.A.C. 8:31A–5.5) and the Rules on Hospital Reporting of Uniform Bill—Patient Summaries regulations (N.J.A.C. 8:31B–2), constitute the minimum necessary steps for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160. These regulations should provide an environment in which to move towards the objectives of an accurate system of monitoring and reporting. This system meets the purpose of the law, to insure the citizens of New Jersey economical provision of necessary and appropriate medical services of the highest quality.

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

Case Notes

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

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

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

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

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

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

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

8:31B–3.2 (Reserved)

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

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

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

(c) Late submission of current cost and financial data, as defined in (b) above and N.J.A.C. 8:31B–4.6(c), including Audited Financial Statements, will result in a penalty for each working day past the appropriate submission date. A fine of $100.00 per working day will be assessed by the Department for late submission of the Acute Care Hospital Cost Reports. A fine of $50.00 per working day will be assessed by the Department for late submission of quarterly financial data specified in (b) above. All of the specified forms, containing the required information, are necessary for a submission to be considered complete. A separate fine of $100.00 per working day will be assessed for late submission of the Acute Care Hospital final audited Financial Statements.

Amended by R.1983 d.597, effective December 19, 1983.
See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
(a): Cross-reference changed from N.J.A.C. 8:31A–5.5 to N.J.A.C. 8:31B–4. (b) added.
Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).
See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).
(b): added "including Audited Financial Statements,".
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Penalty mandatory; to be reflected in next year's rates.
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).
Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
Rewrote (b) and (c).

Case Notes

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

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

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

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

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

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

8:31B–3.11 Same day surgery

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

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

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

2. Had surgery performed in a fully equipped operating room, for example, one routinely equipped and capable of providing general anesthesia, and identified by an operating room charge on the UB–PS;

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

Amended by R.1982, d.427, eff. December 6, 1982.
See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a), 15 N.J.R. 43(a).
Text changed from "Same day surgical units" to provide for "Same day surgery".
Amended by R.1983 d.597, eff. December 19, 1983.
See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
(a) amended; (a) 1, 2 and 3 added.
Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
Reference to 2.1 added.
Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991.)
See: 23 N.J.R. 227(a).
Provision for petition for adjustment deleted at (b).
Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.
See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).
Provisions of emergency amendment R.1991 d.42 readopted without change.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Reporting date in (b) changed to April 30.
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).

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

8:31B–3.16 Aggregate Current Cost Data Base

(a) Once the Department has reviewed the hospital's submission in accordance with N.J.A.C. 8:31B–4 and determined it is suitable for entry into an aggregate current cost data base including data for all hospitals, the Department shall issue a notice of its intent to close the aggregate current cost data base. The notice to each hospital shall include a list of the completeness and/or mathematical adjustments the Department has made.

(b) A hospital which disagrees with the Department's completeness and/or mathematical adjustments shall submit, in writing, a complete list of its exceptions to the adjustments made by the Department within 30 calendar days of the issuance of the notice of intent to close the aggregate current cost data base. If, upon review, the Commissioner determines that there were errors in the completeness and/or mathematical adjustments, a final list of adjustments will be provided to the hospital before the data is entered into the aggregate current cost data base.

(c) A hospital's current cost base submission cannot be substituted or rearranged after the aggregate current cost data base has been closed. Requests to rearrange or substitute current cost base data must be received in writing within 30 calendar days of the issuance of the notice of intent to close the aggregate current cost data base. If, upon review, the Department determines that the revised submission is acceptable, the data entered into the aggregate current cost data base will be based on the revised submission. The Department will advise the hospital of its final list of adjustments.

(d) If a hospital takes exception to the final list of adjustments provided in accordance with (b) or (c) above, it may appeal the final list of adjustments. A notice by a hospital of an intent to appeal the final list of adjustments entered by the Department into the aggregate current cost data base must be submitted in writing to the Commissioner within 15 calendar days of issuance of the final list. Within 30 calendar days of issuance of the final list of adjustments, the hospital shall submit to the Commissioner two copies of its appeal, describing in detail the basis for its challenge to the final list of adjustments. Appeals shall not include new arrangements or substitutions of current cost submission data that was not previously submitted in accordance with (b) above. The appeal document shall list all factual and legal issues, including citation to applicable provisions of the hospital financing rules, and include all written documentation supporting each appeal issue. If the hospital fails to submit the required documentation within the prescribed time frame, it shall have forfeited its right of appeal and the final list of adjustments to the hospital's current cost base submission shall be deemed to have been accepted by the hospital.

1. The Commissioner shall schedule a detailed review to be conducted by the Department with the hospital not more than 45 calendar days following receipt of the appeal document. If the hospital fails to appear on the established date, it shall have forfeited its right of appeal and the final list of adjustments to the hospital's current cost base submission shall be deemed to have been accepted by the hospital.

2. At the detailed review with the hospital, the Department representative shall indicate whether the appeal is supported by sufficient documentation to permit a resolution, and the hospital shall be permitted 10 calendar days after the date of the review in which to submit additional documentation. The Commissioner shall give consideration only to documentation submitted pursuant to the deadlines set forth above in deciding upon any of the hospital's appeal issues.

3. Within 30 calendar days of the review with the hospital, the Commissioner will render detailed findings on the factual and legal issues concerning whether an adjustment to the final list of adjustments to the hospital's current cost base submission is warranted. The Commissioner's decision shall constitute the final agency adjudication.

iii. Medical Administration;

iv. Nursing Administration (persons responsible for more than one functional center);

v. Personnel;

vi. Public Relations;

vii. Communications;

viii. Management Engineering;

ix. Health Sciences Library;

x. Auxiliary Groups;

xi. Travel;

xii. Purchasing and Stores;

xiii. Motor Pool;

xiv. Postage;

xv. Medical Library;

xvi. Medical Photography and Illustration;

xvii. Licenses and Taxes (other than income taxes and payroll taxes);

xviii. Insurance (other than Malpractice and Employees Fringe Benefits);

xix. Security;

xx. Planning;

xxi. Professional Association Memberships;

xxii. Legal and Audit Fees;

xxiii. Duplicating and Printing;

Amended by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B–4.119 Fiscal (FIS)

Fiscal includes Admitting and Outpatient registration, cashiering (excluding cafeteria), patient billing and receivables (including outpatients), financial administration and controllership, data processing (as it relates to these functions), payroll, accounts payable, general ledger, budgets and reimbursement, fund accounting and internal audit.

Repeal and New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Inpatient Administrative Services (IAM)".

8:31B–4.120 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Outpatient Administrative Services (OAM)".

8:31B–4.121 Malpractice Insurance (MAL)

Function: Malpractice Insurance should include the institution's total premium or self-insurance cost for hospital and professional liability coverage. No other type of insurance coverage is to be included here.

8:31B–4.122 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Employee Health Insurance (EHI)".

8:31B–4.123 (Reserved)

Repealed by R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).
Section was "Repairs and Maintenance (RPM)".

8:31B–4.124 Utilities Cost (UTC)

(a) Function:

1. The center should be used to account for all utility costs such as electricity, gas, oil, disposal services and water. A breakdown of the cost and source of these utilities should be provided per N.J.A.C. 8:31B–4.131.

2. Telephones are not considered utilities and thus such costs and revenues are not to be reported in this center. Costs associated with utilities provided to buildings and areas not involved in patient care are to be excluded and reported as reconciliations per instructions in N.J.A.C. 8:31B–4.62 through 4.66 and N.J.A.C. 8:31B–4, Part VI.

8:31B–4.125 Interest (INT)

The interest cost center includes the total cost of interest incurred by the institution. All interest costs related to the acquisition of institutional facilities should be reported as facilities interest. Working capital interest is reported as other expense in this cost center. Interest not applicable to services related to patient care (for example, rental of apartments) should be reported as reconciliations per N.J.A.C. 8:31B–4, Part IV and N.J.A.C. 8:31B–4.131.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B–4.126 Legal Fringe Benefits (LFB)

The Legal Fringe Benefits cost center should include the cost of all employee benefits required by law such as: FICA–OASDI, FICA–Medicare, worker's compensation, unemployment compensation and disability insurance.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B–4.127 Pensions (PEN)

The Pensions cost center should include the cost of all pensions and annuity plans for hospital employees.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B–4.128 Policy Fringe Benefits (PFB)

(a) The Policy and Fringe Benefits cost center should include the cost of all employee benefits granted by institution policy, excluding pension costs, such as: medical insurance, life insurance, other employee related insurance (excluding malpractice), deferred compensation, tuition reimbursement and other employee recognition programs.

(b) Employee Health Insurance includes all premium payments and associated costs with union or group health insurance for employees. Hospitals which self-insure for employees, health insurance should report no insurance costs in this cost center; however, deductions from operating revenue for personnel health programs are to be reported by cost center.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B–4.129 Reconciling Items (RIT)

The Reconciling Items cost center should include the difference between total institutional costs from the hospitals' certified financial statements and the cost of services related to hospital patient care. The costs of services not related to patient care should also be reported as reconciliations per N.J.A.C. 8:31B–4 and N.J.A.C. 8:31B–4.131.

New Rule, R.1995 d.507, effective September 5, 1995.
See: 27 N.J.R. 2148(a), 27 N.J.R. 3481(a).

8:31B–4.130 (Reserved)

8:31B–4.131 Financial elements report

The Commissioner of Health and Senior Services shall approve Financial Elements report forms, also known as Acute Care Hospital Cost Reports, and reporting instructions consistent with the five Parts of the Financial Elements and Reporting Regulations for completion by all New Jersey hospitals. The Commissioner may refine these report forms for research purposes by adding, modifying, or changing cost centers.

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).
(b) deleted.
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).
Amended by R.2000 d.339, effective August 21, 2000.
See: 32 N.J.R. 1364(a), 32 N.J.R. 3059(b).
Inserted a reference to Acute Care Hospital Cost Reports.

SUBCHAPTER 5. STANDARDS FOR HOSPITAL NOTIFICATION REGARDING OFFSET OF MEDICAID PAYMENTS AND CHARITY CARE SUBSIDY PAYMENTS TO COLLECT HOSPITAL DEBTS DUE TO THE STATE

8:31B–5.1 Hospital notification regarding offset

(a) The Department of Human Services' Division of Medical Assistance and Health Services will, upon receipt of documentation from the Department of Health and Senior Services, apply an offset to a hospital's Medicaid payments to collect delinquent statutory and/or regulatory debts owed by the hospital to the State.

(b) On the 10th day after the due date, the Department of Health and Senior Services shall send each hospital that is delinquent in paying its statutory and/or regulatory debt a notice of intent to initiate an offset to its Medicaid payments.

(c) If the Department of Health and Senior Services receives a payment from a hospital for the delinquent amount after an offset has been initiated, the amount of offset shall be applied to any statutory debts owed by the hospital to the State within the next 30 days.

(d) The Department of Health and Senior Services shall request the Division of Medical Assistance and Health Services to initiate maximum offsets until individual hospital debts are satisfied. Offset payment schedules may be negotiated with individual hospitals based on financial stability.

SUBCHAPTER 6 THROUGH 7. (RESERVED)

APPENDIX I

(RESERVED)

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

APPENDIX II

(RESERVED)

Amended by R.1985 d.189, effective April 15, 1985.
See: 17 N.J.R. 153(a), 17 N.J.R. 914(a).
Section substantially amended.
Amended by R. 1985 d.551, effective November 4, 1985.
See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).
Labor 1. Proxies completely amended.
Amended by R.1989 d.78, effective February 6, 1989.
See: 20 N.J.R. 2543(a), 21 N.J.R. 297(a).
Changed household linens 40% to Textile home furnishings 40% and household linens 20% to Textile home furnishings 20%.
Amended by R.1989 d.387, effective July 17, 1989.
See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).
Labor proxy adjustment factor added.
Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
Clarification of derivation of economic factor.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Text deleted.

APPENDIX III

(RESERVED)

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Text at E.-G. deleted; H recodified.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Was "Preliminary Cost Base Report".

APPENDIX IV

(RESERVED)

Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Was "Preliminary Cost Base Gross Revenue Requirements".

APPENDIX V

(RESERVED)

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
References to 1980 deleted.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Was "Revenue Budget Worksheet/Submitted Budget Supplied by NJDOH–Completed by Hospital".

APPENDIX VI

(RESERVED)

Administrative Correction to delete "DRG 383" and "Outpatient Dialysis".
See: 22 N.J.R. 3229(b).
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Was "Computation of reasonable direct patient care costs".

APPENDIX VII

(RESERVED)

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Financial elements changed.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Was "Preliminary Cost Base Reconciliation to Net Revenue Related to Patient Care".

APPENDIX VIII

(RESERVED)

Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
Dialysis deleted.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Direct and indirect cost items revised; payer classes introduced.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Was "Schedule of Rates as Adjusted for Compliance".

APPENDIX IX

(RESERVED)

Amended by R.1989 d.387, effective July 17, 1989.
See: 21 N.J.R. 135(a), 21 N.J.R. 2058(c).
Specification for Rate Years through 1988 added.
Repealed by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
Appendix IX, Volume Variability Adjustment, deleted.

APPENDIX X

(RESERVED)

Repealed by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
Appendix X, Nursing Cost Allocation Methodology, deleted.

APPENDIX XI

(RESERVED)

Amended by R.1989 d.388, effective July 17, 1989.
See: 21 N.J.R. 1059(a), 21 N.J.R. 2082(a).
Amended by R.1990 d.266, effective May 21, 1990.
See: 22 N.J.R. 735(a), 22 N.J.R. 1591(a).
Medicine—Pediatrics added at I(a)10; Rehabilitation added at 14; DRGs conformed to New York Grouper 7.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
GME reimbursement methodology revised.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Was "Reimbursement Methodology for Graduate Medical Education".