

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Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric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.

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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

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 by multiplying the hospital's actual charity care service charges by the hospital-specific ratio of Medicaid payments to hospital charges. 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 the N.J.A.C. 10:52-11.7(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.

10:52-11.4 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 section through N.J.A.C. 10:52-11.9. 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.

(j) Hospitals with a Federal Hill Burton obligation at the time of the application may include applicants written-off to the Hill Burton Program as eligible for charity care if the applicant meets all of the eligibility standards and documentation requirements set forth in this section through N.J.A.C. 10:52-11.10.

(k) The Charity Care Program shall be the payer of last resort, except for the payers identified in (h) and (i) above.

(l) A charity care applicant shall be eligible for charity care for services rendered per N.J.A.C. 8:31B-4.38 on or after January 1, 1995 if he or she meets the criteria in this section through N.J.A.C. 10:52-11.9.

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

In (a) and (b), substituted references to the Department of Health and Senior Services for references to the Essential Health Services Commission; in (d)2, substituted a reference to county boards of social services for a reference to county welfare offices; and in (i), (j) and (l), changed N.J.A.C. references.

10:52-11.5 Identification

(a) Applicants for charity care shall provide the hospital with the following proper identification: Paragraph (a)3 below represents an alternative measure for documenting identification as described in N.J.A.C. 10:52-11.10.

1. The applicant shall provide the hospital with one of the following identification documents: driver's license, social security card, alien registry card, birth certificate, baptismal certificate, paycheck stub, passport, visa, death certificate, employee identification, or attestation that the person is homeless and does not possess any of the above mentioned identification documents. If the documents listed above are not available to the applicant, the hospital staff shall document why the applicant was unable to comply for medical reasons, such as, if the applicant is deceased, or noncommunicative until discharge for medical reasons, and a person to identify the patient cannot be found, the requirement for identification shall be waived.

2. The applicant shall provide the hospital with one of the following documents containing his or her name and address: a driver's license, a voter registration card, a union membership card, an insurance or welfare plan identification card, a student identification card, a utility bill, a Federal income tax form, a state income tax form, or an unemployment benefits statement. If the documents listed above are not available to the applicant, the hospital staff shall document why the applicant was unable to comply and shall ask for proof of identification as described in (a)3 below.

3. The applicant shall provide proof of identification in one of the following ways: a piece of mail addressed and delivered to the applicant; a signed attestation (which includes the party's name, address and telephone number) from a third party attesting to the applicant's identity; or a signed statement attesting to his or her own identity.

(b) The hospital shall obtain a photocopy of the applicant's identification or attestation and shall produce the copy on audit.

(c) The hospital shall attempt to collect the following information regarding the applicant and, if applicable, the responsible party: name; mailing address; residence telephone number; date of birth; social security number; place and type of employment; and employment address and telephone number, as applicable.

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), changed N.J.A.C. reference in the introductory paragraph, inserted a reference to baptismal certificates and paycheck stubs in 1, and inserted a reference to drivers licenses and deleted a reference to baptismal certificates and paycheck stubs in 2.

10:52-11.6 New Jersey residency

(a) Applicants for charity care shall provide the hospital with proof of New Jersey residency. An applicant shall

provide proof that he or she has been residing in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. Paragraph (a)3 below represents an alternative measure for documenting proof of residency.

1. The applicant shall provide the hospital with any of the identification documents listed in N.J.A.C. 10:52-11.5(a)2 that contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. The hospital may accept an attestation from the applicant that he or she is homeless. If the applicant is unable to provide one of the documents listed at N.J.A.C. 10:52-11.5(a)2, the hospital staff shall document why the applicant was unable to comply, and shall ask for proof of residency as described in (a)2 below.

2. If the applicant cannot provide any of the documentation listed in N.J.A.C. 10:52-11.5(a)2 the applicant shall supply a copy of any undated identification listed in N.J.A.C. 10:52-11.5(a)1 and this paragraph, or any mail received showing the applicant's name and current residence address. If the applicant is unable to provide these documents, the hospital staff shall document why the applicant was unable to comply and ask for proof of residency as described in (a)3 below.

3. The applicant shall provide a signed attestation stating that he or she has been residing in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State.

(b) Non-New Jersey residents requiring immediate medical attention for an emergency medical condition may apply for charity care. Emergency medical condition shall be restrictively defined as a serious medical situation requiring immediate treatment, in which delay would cause serious risk to life or health. Services available to non-New Jersey residents shall include only those not reasonably available at an alternative non-New Jersey site at the time services are requested.

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), changed N.J.A.C. references throughout, and rewrote 2.

10:52-11.7 Income eligibility criteria and documentation

(a) The hospital shall determine the applicant's family size in accordance with this section. Family size for an adult applicant includes the applicant, spouse, any minor children whom he or she supports, and adults for whom the applicant is legally responsible. The family size for a minor applicant includes both parents, the spouse of a parent, minor siblings and any adults in the family for whom the applicant's parent(s) are legally responsible. If an applicant documents that he or she has been abandoned by a spouse or parent, that spouse or parent shall not be included as a

family member. A pregnant female counts as two family members.

(b) The provisions of 42 U.S.C. 9902(2), the poverty guidelines revised annually by the United States Department of Health and Human Services (HHS), are hereby incorporated by reference. (For further information on the poverty guidelines, contact the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C. 20201, Telephone (202) 690-6141.) A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

1. A person whose individual or, if applicable, family income, as determined by (e) below, is less than or equal to 200 percent of the HHS Poverty Guidelines shall be eligible for charity care for necessary health services without cost.
2. A person whose individual or, if applicable, family income as determined by (e) below, is greater than 200 percent of the HHS Poverty Guidelines but not more than 300 percent of these guidelines is eligible for charity care at a reduced rate as described in (c) below.

(c) A person who is eligible for reduced charge health services shall be charged a percentage of the normal charge for health services as described in the table below. The reduced percentage can be applied to the total bill or, until July 1, 1995, to any remainder after third party payment. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

Income as a percentage of HHS Poverty Guidelines	Percentage of Charges Paid by Applicant
>200 to 225	20
>225 to 250	40
>250 to 275	60
>275 to 300	80

(d) If qualified medical expenses, as defined for the purposes of Federal income tax deductibility, for applicants eligible for reduced charge charity care exceeds 30 percent of the applicant's or family's, if applicable, annual gross income as calculated by (e) below, such excess will be eligible for 100 percent coverage under charity care. The 30 percent threshold must be met once per family in a 12 month period.

(e) An applicant's income, for the purpose of determining eligibility for charity care or reduced charge charity care, shall be determined as follows:

1. The applicant may provide proof of the actual gross income for the 12 months immediately preceding the services;

2. The applicant may provide proof of actual gross income for the three months immediately preceding services. The hospital shall multiply this amount by four to determine the gross annual income; or

3. The applicant may provide proof of actual gross income for the month immediately preceding service. The hospital shall multiply this amount by 12 to determine the gross annual income.

4. If the applicant provides documentation for more than one salary period specified in paragraphs (e)1 through 3 above, the hospital shall use the period of time during which the salary was the lowest.

5. If the applicant is a welfare recipient and has not documented income as described in (e)1 through 3 above, the hospital shall document income status by obtaining a photocopy of the applicant's welfare identification, and document that the staff of the hospital obtained verification in writing or by phone of the applicant's current benefit amount from the appropriate local welfare office.

6. An applicant shall supply a signed attestation showing his or her unreported income in order for that income to be considered in the eligibility determination, as described in (b) above.

10:52-11.8 Proof of income

(a) Applicants for charity care shall provide the hospital with proof of income as listed below. Paragraph (a)3 below shall be considered alternative documentation, as described in N.J.A.C. 10:52-11.10.

1. An applicant shall provide the hospital with proof of income, which includes the following items: Federal or State income tax return; pay check stubs; W-2 forms; a letter from an employer on company letterhead stating the applicant's income; or a statement of the gross benefit amount from any governmental agency providing benefit to the applicant. If an applicant has been employed for at least one month, he or she may document his or her income by providing one paycheck stub immediately prior to the date of service if the paycheck stub indicates a year-to-date income, and if the applicant documents the length of time he or she has been employed by the employer.

- i. If an applicant is a recipient of Social Security benefits, he or she may document this income by either providing the annual benefits statement from the Social Security Administration, or copies of bank statements from three months prior which indicate direct deposit of the social security check, or a copy of one social security check.

- ii. An applicant with no income or benefits of any type may present the hospital with a signed attestation to this effect. If the applicant is homeless, the hospital may accept a signed attestation which states that the applicant is homeless and receives no support, income or benefits.

iii. If the applicant is unable to provide one of the documents listed above, the hospital staff shall document reasons for the applicant's inability to comply and request the documentation listed in (a)2 below.

2. An applicant may document his or her income by providing one paycheck stub immediately prior to the date of service. If the applicant is unable to provide this documentation, the hospital staff must document reasons for the applicant's inability to comply and request the documentation listed in (a)3 below.

3. An applicant may document his or her income by providing an attestation which states the income received in one of the time periods described in N.J.A.C. 10:52-11.7(e)1 through 3.

(b) Family income that must be considered for the eligibility determination includes the income of all members for whom the applicant is legally responsible including, but not limited to, a spouse and any minor children for an adult. For a minor applicant, the income of the family, as determined by N.J.A.C. 10:52-11.7(a), will be considered. In situations where a minor applicant's parents are divorced, and the custodial parent(s) are remarried, the nonparental spouse's income shall be considered. In situations where both divorced parents have responsibility for the minor applicant's medical care, each parent shall complete a charity care application. For a minor applicant, the income of the family shall be considered, except for earned income of the minor child and siblings. In cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available by the following steps in (c) below.

(c) If a minor applicant's parents are divorced, and one of the parents is uncooperative, as defined in (c)1 through 3 below, with the application process, the requirement for that parent's income may be waived by the hospital, after the case is reviewed by the Department of Health and Senior Services based on the following:

1. A parent or spouse may be deemed uncooperative if the applicant documents at least one unsuccessful attempt to obtain the necessary information from the parent or spouse; and

2. The parent or spouse does not respond to a letter from the hospital indicating the possibility of collection or legal action if he or she does not provide the necessary information for the application; and

3. The parent or spouse does not respond to the hospital in-house collection process.

(d) If an applicant is separated, but not legally divorced, from his or her spouse, the applicant may document that he or she has no financial ties with the estranged spouse in accordance with (d)1 through 4 below, and the hospital may waive the requirement for the estranged spouse's income,

after the case is reviewed by the Department of Health and Senior Services, if documentation has been provided in accordance with the following:

1. A separated spouse may be deemed to have no financial ties to the applicant if the applicant provides proof to the hospital that he or she is not living with the estranged spouse, and does not own any property or share a lease to a rental property with the estranged spouse; and

2. The applicant provides a copy of his or her most recent tax return indicating that the applicant filed taxes separately. If estrangement occurred after filing jointly, the hospital may hold the application until the applicant files the next tax return separately. If an applicant does not file tax returns, he or she must sign an attestation to this effect explaining his or her reasons; and

3. The applicant provides copies of all his or her financial accounts showing the applicant with sole ownership of his or her assets; and

4. The applicant provides an affidavit stating that he or she is separated from and has no financial ties to the estranged spouse.

(e) The hospital may request that the applicant document his or her living expenses.

(f) A minor applicant who documents that both parents have abandoned him or her shall provide documentation of the income and assets of his or her guardian(s).

(g) The hospital may accept a charity care determination from another New Jersey hospital as proof of income, provided that the effective date of the charity care determination is not more than one year earlier than the date of service at the second hospital and that the second hospital verifies the determination with the hospital that issued the determination. The determination by the second hospital is valid for one year from the effective date of the first hospital's determination.

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

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

In (a) and (b), changed N.J.A.C. references throughout.

10:52-11.9 Assets eligibility criteria

(a) An applicant shall provide proof that:

1. His or her individual assets as of the date of service do not exceed \$7,500; and

2. His or her family's assets, if applicable, do not exceed \$15,000 as of the date of service.

(b) Family members whose assets must be considered are all legally responsible individuals as defined in N.J.A.C. 10:52-11.7(a).

(c) Assets, as used in this section, are items which are, or which can be readily converted into, cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, Individual Retirement Accounts (IRAs), trust funds, and equity in real estate other than the applicant's or family's, if applicable, primary residence. A primary residence, for purposes of charity care, is defined as a structure within which the applicant currently lives. If an applicant jointly owns assets with another person(s), for whom the applicant is not legally responsible, the value of these assets shall be prorated equally among all the owners.

(d) The applicant shall document the value of all applicable assets as described in (d)1 through 3 below. Paragraph (d)3 below represents alternative documentation as described in N.J.A.C. 10:52-11.7.

1. The applicant shall present the hospital with a statement from a bank or other applicable financial institution showing the value of the asset(s) as of the date of service. If an applicant has no assets, he or she may sign an attestation to that effect, and this fulfills the requirement for proof of assets. If the applicant is unable to obtain such documentation, the hospital staff shall document, in writing, the reason why the proof could not be provided, and request proof of assets as described in (d)2 below.

2. The applicant shall provide the hospital with a statement from the bank or other applicable financial institution showing the average daily balance of the asset(s) within one month of the date of service. If the applicant is unable to obtain such documentation, the hospital staff shall document, in writing, the reason why the proof could not be provided, and request proof of assets as described in (d)3 below.

3. The applicant shall present the hospital with a signed statement attesting to the type and value of the assets.

(e) The assets of an applicant for charity care shall be counted only after the applicant has had an opportunity to apply any amount of assets in excess of the limits in (a) above toward qualified medical expenses. Qualified medical expenses are those amounts deductible for the purpose of calculation of Federal income tax liability.

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) and (d), changed N.J.A.C. references.

10:52-11.10 Limit on accounts with alternative documentation

The total of all sample dollars in which identification, New Jersey residency, income, and assets documented by the alternative procedures described in N.J.A.C. 10:52-11.5(a)3, 11.6(a)3, 11.8(a)3 or 11.9(d)3, shall be limited to no more than 10 percent of the total dollars sampled on audit. Sample dollars that exceed 10 percent on the expanded sample shall be adjusted in accordance with N.J.A.C. 10:52-11.14(b).

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.

10:52-11.11 Additional information to be supplied to facility by applicant

(a) A hospital shall, as a condition of finding any applicant eligible for charity care or reduced charge charity care, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and assets and that is within the applicant's ability to supply.

(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.

10:52-11.12 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.

10:52-11.13 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.

10:52-11.14 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. 10:52-11.4 through 11.10. 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.

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 ser-

VICES; 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.