

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

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

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

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

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

In (b), deleted 1; substituted "FamilyCare" for "KidCare" through-out.

SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

10:52-9.1 Review and appeal of rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Notes

Division of Medical Assistance and Health Services (DMAHS) properly denied hospital's request for a rate review based on hospital's failure to submit information responsive to one or more of the regulatory criteria. In re: St. Francis Medical Center (Trenton) 1995 Medicaid Rates, 1998 WL 34327844, N.J. Adm., Ma6 16, 1998, (NO. HMA 2252-96).

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

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

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

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

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

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

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

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

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

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

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

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

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

10:52-10.1 Introduction

(a) The New Jersey Medicaid/FamilyCare fee-for-service program utilizes the Healthcare Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology architecture, employing a five position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the CMS assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three level coding system.

1. LEVEL I CODES (Narratives found in CPT)