

CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D-6 and 7; 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(13), 1396a(a)(33), 1396a(a)(44), 1396(d), 1397cc and 1397jj.

Source and Effective Date

R.2005 d.214, effective June 9, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

Chapter Expiration Date

Chapter 52, Hospital Services Manual, expires on June 9, 2010.

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Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric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: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Chapter 52, Hospital Services Manual, was readopted as R.2005 d.214, effective June 9, 2005. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

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

SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

- 10:52-2.1 Ambulatory Surgical Center (ASC)
- 10:52-2.2 Blood and blood products
- 10:52-2.3 Dental services
- 10:52-2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- 10:52-2.5 Family planning services
- 10:52-2.6 Home health agencies; hospital-based
- 10:52-2.7 Medical day care centers; hospital affiliated
- 10:52-2.8 Substance abuse treatment centers; free-standing
- 10:52-2.9 Organ procurement and transplantation services
- 10:52-2.10 Psychiatric services; partial hospitalization
- 10:52-2.10A Psychiatric services; partial hospitalization prevocational programs

- 10:52-2.11 Rehabilitative services; hospital outpatient department
- 10:52-2.12 Renal dialysis services for end-stage renal disease (ESRD)
- 10:52-2.13 Sterilization
- 10:52-2.14 Hysterectomy
- 10:52-2.15 Termination of pregnancy
- 10:52-2.16 Transportation services; hospital-based

SUBCHAPTER 3. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES

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

SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

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

SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

- 10:52-5.1 Derivation of Preliminary Cost Base
- 10:52-5.2 Uniform Reporting: Current costs
- 10:52-5.3 Costs per case
- 10:52-5.4 Development of standards
- 10:52-5.5 Current Cost Base
- 10:52-5.6 Financial elements reporting/audit adjustments
- 10:52-5.7 Identification of direct and indirect costs related to Medicaid/FamilyCare patient care
- 10:52-5.8 Patient care cost findings; direct costs per case, physician and nonphysician
- 10:52-5.9 Reasonable cost of services related to patient care
- 10:52-5.10 Standard costs per case
- 10:52-5.11 Reasonable direct cost per case

- 10:52-5.12 Net income from other sources
- 10:52-5.13 Update Factors
- 10:52-5.14 Capital facilities
- 10:52-5.15 Division adjustments and approvals
- 10:52-5.16 Derivation from Preliminary Cost Base
- 10:52-5.17 Schedule of rates—effective date
- 10:52-5.18 (Reserved)
- through
- 10:52-5.21

SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

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

- 10:52-6.71 Graduate Medical Education (GME)
- 10:52-6.72 General Administrative Services (GAM)
- 10:52-6.73 Inpatient Administrative Services (IAM)
- 10:52-6.74 Malpractice Insurance (MAL)
- 10:52-6.75 Employee Health Insurance (EHI)
- 10:52-6.76 Repairs and Maintenance (RPM)
- 10:52-6.77 Utilities Cost (UTC)
- 10:52-6.78 through 10:52-6.79 (Reserved)

SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

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

SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

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

SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

- 10:52-9.1 Review and appeal of rates

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

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

SUBCHAPTER 11. CHARITY CARE

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

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

- 10:52-12.1 Definitions
- 10:52-12.2 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund
- 10:52-12.3 Basis of pricing for charity care claims

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

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

APPENDIX A. FISCAL AGENT BILLING SUPPLEMENT

APPENDIX B. EMC MANUAL

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 FamilyCare 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 FamilyCare fee-for-service beneficiaries and to Medicaid and NJ FamilyCare 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 in accordance with the Division's rules for MCOs at N.J.A.C. 10:74, the MCO's policies and procedures, and the MCO's provider contract with the State, and all amendments thereto.

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 sub-

stituted a reference to psychiatric hospitals for a reference to private psychiatric hospitals; and added (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 (a), substituted "FamilyCare" for "KidCare"; rewrote (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.

"Adult acute partial hospital" or "APH" means an intensive and time-limited acute psychiatric service for beneficiaries 18 years of age or older who are experiencing, or are at risk for, rapid decompensation. This mental health service is intended to minimize the need for hospitalization.

"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.

"Centers for Medicare & Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program.

"Clinically licensed mental health professional" means a mental health professional possessing a Master's or Doctoral degree from an accredited university in psychiatry, psychology, social work, psychiatric nursing or psychiatric rehabilitation counseling. In addition to the degree, the applicable training must be completed, including the appropriate residency (fellowship), internship or student placement required by the professional standards of the respective discipline, as well as the applicable State license.

"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.

"Disproportionate share hospital" means a hospital designated as such by the Commissioner of the Department of Human Services, in accordance with N.J.A.C. 10:52-13.

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

"Division of Disability Services (DDS)" means the agency located within the Department which is designated as the agency responsible for information and referral for all individuals with disabilities.

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid and NJ FamilyCare-Children's Program-Plan A beneficiaries under 21 years of age 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. 10:52-1.3, 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. 10:52-5.9).

"Group outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders which involves a group of usually four to 12 beneficiaries who have similar problems and treatment needs. The group meets regularly with a therapist who uses the interaction of the group members to relieve distressful symptoms and modify beneficiaries' behavior.

"Group outpatient hospital psychiatric services for youth or young adults" means an outpatient therapeutic intervention for a youth or young adult with similar behaviors or functionality provided in a group of no more than eight individuals, in which interventions are provided directly by or under the direction of a clinically licensed mental health professional.

"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 meets the following requirements:

1. Is primarily engaged in providing 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 rehabilitation services for the rehabil-

iii. Primary caregiver is not able to provide required care services; or

iv. Lack of adequate support systems.

3. The financial criteria are as follows. Does the patient meet any of the income and asset tests:

i. Currently eligible for Medicaid or NJ FamilyCare-Plan A;

ii. Monthly income at/or below the current institutional level specified at N.J.A.C. 10:71-5.6.

(1) Has no spouse in the community and resources no greater than those specified at N.J.A.C. 10:71-4.4 and 4.5;

(2) Has no spouse in the community and has resources at or below the maximum amount allowable, as determined by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Medicare Catastrophic Coverage Act of 1988 (see N.J.A.C. 10:71). (This is an indication that the patient may become Medicaid or NJ FamilyCare-Plan A eligible within the next six months by spending down assets in an NF as private pay); or

(3) Has a spouse in the community with combined countable resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see N.J.A.C. 10:71).

iii. Monthly income at or below the current New Jersey Care . . . Special Medicaid programs maximum monthly income limit specified at N.J.A.C. 10:72-4.1 and:

(1) Has no spouse in the community and resources no greater than those specified at N.J.A.C. 10:71-4.4 and 4.5;

(2) Has no spouse in the community and resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see N.J.A.C. 10:71). This is an indication that the patient may become Medicaid or NJ FamilyCare-Plan A eligible within the next six months by spending down assets in an NF as private pay; or

(3) Has a spouse in the community with combined countable resources at or below the maximum amount allowable, as determined by CMS in accordance with the Medicare Catastrophic Coverage Act of 1988 (see N.J.A.C. 10:71).

(h) The hospital discharge planner or social worker shall be responsible for the discharge or placement arrangements of the patient.

1. For each hospital patient referred for PAS, the hospital shall complete and send to the OCCO a "Hospital Preadmission Screening Discharge form (LTC-8)."

i. For any patient discharged to a NF, a Discharge Package (HSDP, discharge paper work, DHSS approval letter, hospital transfer sheet and PASRR documentation, including any documentation which supports a diagnosis of Alzheimer's disease or related organic dementia) shall be compiled to accompany the patient to the NF.

(1) If the patient being transferred to a NF is eligible for Medicare benefits, the transfer shall be made to a Medicare/Medicaid participating NF.

ii. For those beneficiaries discharged to community locations, the hospital social worker or discharge planner shall be responsible for the implementation of the HSDP by securing home care services.

Recodified from N.J.A.C. 10:52-1.9 by R.1998 d.564, effective December 7, 1998.

See: 30 N.J.R. 1257(a), 30 N.J.R. 4225(a).

Former N.J.A.C. 10:52-1.10, Recordkeeping, recodified to N.J.A.C. 10:52-1.11.

Recodified from N.J.A.C. 10:52-1.10 and amended by R.2000 d.29, effective January 18, 2000.

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

Rewrote the section. Former N.J.A.C. 10:52-1.11, Recordkeeping, recodified to N.J.A.C. 10:52-1.12.

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

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

Rewrote the section.

10:52-1.12 Recordkeeping

Hospitals shall be required to keep legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. This information shall be available upon the request of the Division or its agents.

Recodified from N.J.A.C. 10:52-1.10 by R.1998 d.564, effective December 7, 1998.

See: 30 N.J.R. 1257(a), 30 N.J.R. 4225(a).

Former N.J.A.C. 10:52-1.11, Second opinion program for elective surgical procedures, recodified to N.J.A.C. 10:52-1.12.

Recodified from N.J.A.C. 10:52-1.11 by R.2000 d.29, effective January 18, 2000.

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

Former N.J.A.C. 10:52-1.12, Second opinion program for elective surgical procedures, recodified to N.J.A.C. 10:52-1.13.

10:52-1.13 Second opinion program for elective surgical procedures

(a) A second opinion shall be obtained for any elective surgical procedures listed under (b) below. The outcome of the second opinion shall have no bearing on reimbursement. Once the second opinion is rendered, the beneficiary shall retain the right to decide whether or not to proceed with the surgery; however, failure to obtain a second opinion for these procedures shall result in a denial of the hospital claim.

1. If the operating physician determines that the need for surgery is urgent or is an emergency, no second opinion shall be required. "Urgent" or "emergency" includes any situation in which a delay in performing surgery in order to meet the second opinion requirement could result in a significant threat to the patient's health or life.

i. Reimbursement for urgent or emergency surgery shall be made only if a specific statement is attached to the claim form by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. If the Medicaid or NJ FamilyCare beneficiary is covered by another health insurance carrier (except Medicare) which makes only partial payment on the claim, the fiscal agent shall not make supplementary payment unless the second opinion requirement has been met. However, the fiscal agent shall make payment on the claim if the hospital receives documentation that a second opinion was arranged for and paid for by another health insurance carrier. A copy of this documentation shall be attached to the claim form.

(b) The following elective surgical procedures fall under the Second Opinion Program:

1. Hernia Repair (common abdominal wall type);

i. A second opinion shall be required for any herniorrhaphy involving an adult over 18 years of age.

ii. A second opinion shall not be required for herniorrhaphy involving a child or young adult 18 years of age or under.

2. Hysterectomy (See also N.J.A.C. 10:52-2.14);

3. Laminectomy;

4. Spinal fusion;

i. A second opinion shall not be required for spinal fusion for scoliosis in a child or young adult 18 years of age or under.

(c) A second opinion shall be arranged through the Medicaid Second Opinion Referral Services of the Provider Services Unit at the fiscal agent.

1. A consultation ordered by a physician shall not meet the Program's definition of a second opinion and no "Authorization for Payment" shall be granted based on such a consultation. The only exception to this policy involves second opinions arranged and paid for by other health insurance carriers. (See (a)2 above.)

2. In order to prevent claim denial as a result of a situation in which one of the elective surgical procedures is scheduled and performed before the second opinion requirement is met, it is suggested that the elective surgery not be scheduled until after the second opinion has been rendered.

(d) Neither the physician claim nor hospital claim associated with one of the second opinion procedures shall be paid unless attached to the hard copy is an "Authorization for Payment," or documentation of a second opinion arranged through another health insurance carrier, or a specific statement from the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

1. Reimbursement shall not be made for a second opinion rendered to an individual who is not a Medicaid or NJ FamilyCare fee-for-service beneficiary. The issuance of a Second Opinion Referral to the beneficiary by the Program's Second Opinion Referral Services of the Provider Services Unit shall not guarantee the individual's eligibility on the date of the second opinion or subsequent surgery. The individual's current Medicaid or NJ FamilyCare eligibility shall be verified by checking the individual's current New Jersey Validation Form before rendering any service. (See N.J.A.C. 10:49-2.2 and 2.5, Administration—How to Identify a Medicaid or NJ FamilyCare Beneficiary).

(e) For physician requirements regarding Second Opinion procedures, see N.J.A.C. 10:54, Physician Services.

Amended by R.1998 d.352, effective July 20, 1998.

See: 30 N.J.R. 1258(a), 30 N.J.R. 2653(a).

In (a), substituted "beneficiary" for "recipient" in the introductory paragraph and inserted a reference to NJ KidCare in 2; in (b), rewrote 1, changed the N.J.A.C. reference in 2, and deleted 5; and in (d)1, substituted "beneficiary" for "recipient", deleted references to Medicaid, and inserted references to NJ KidCare throughout.

Recodified from N.J.A.C. 10:52-1.11 by R.1998 d.564, effective December 7, 1998.

See: 30 N.J.R. 1257(a), 30 N.J.R. 4225(a).

Former N.J.A.C. 10:52-1.12, Social Necessity Days, recodified to N.J.A.C. 10:52-1.13.

Recodified from N.J.A.C. 10:52-1.12 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted a reference to reimbursement for a reference to payment in the introductory paragraph, and substituted a reference to NJ KidCare Plan—A, B or C beneficiaries for a reference to NJ KidCare beneficiaries; in (b)2 and (d)1, changed N.J.A.C. references; and in (d)1, substituted a reference to NJ KidCare fee-for-service beneficiaries for a reference to NJ KidCare beneficiaries. Former N.J.A.C. 10:52-1.13, Social Necessity Days, recodified to N.J.A.C. 10:52-1.14.

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)2, and (d)1, substituted references to FamilyCare for references to KidCare.

10:52-1.14 Social Necessity Days

(a) Payment for "Social Necessity Days" shall be made to hospitals for a maximum of 12 calendar days per hospitalization for a Medicaid or NJ FamilyCare—Children's Program fee-for-service beneficiary child admitted with the diagnosis of child abuse or suspected child abuse, if special circumstances (social necessity) prevent the discharge or transfer of the patient and the hospital has taken effective action to initiate discharge or transfer of the patient.

1. For these cases, it is not necessary for the day of admission to be at the acute level of care.

2. Effective action is defined as telephone notification to the county board of social services (CBOSS), or Division of Youth and Family Services (DYFS) district office, or other responsible officials as may be designated, within 48 hours of the time that the stay is determined to be no longer medically necessary. This telephone contact shall then be confirmed in writing within three working days. A copy of the written notification shall be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).

3. Medicaid or NJ Family Care—Children's Program reimbursement for social necessity shall be made to hospitals paid in accordance with the DRG rate setting methodology in N.J.A.C. 10:52-5 through 9.

Recodified from N.J.A.C. 10:52-1.12 by R.1998 d.564, effective December 7, 1998.

See: 30 N.J.R. 1257(a), 30 N.J.R. 4225(a).

Former N.J.A.C. 10:52-1.13, Utilization control (inpatient services), recodified to N.J.A.C. 10:52-1.14.

Recodified from N.J.A.C. 10:52-1.13 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted a reference to Medicaid and NJ KidCare—Plan A fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph, substituted a reference to CBOSS for a reference to CWA in 2, and substituted a reference to Medicaid and NJ KidCare—Plan A reimbursement for a reference to Medicaid reimbursement in 3. Former N.J.A.C. 10:52-1.14, Utilization control (inpatient services), recodified to N.J.A.C. 10:52-1.15.

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

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

In (a), substituted "FamilyCare—Children's Program" for "KidCare Plan A" in the introductory paragraph and 5.

10:52-1.15 Utilization control (inpatient services)

(a) This section provides information on the requirements for utilization control for inpatient services for approved acute general hospitals, special hospitals, and private psychiatric hospitals, with the exception of inpatient psychiatric hospital services for individuals under the age of 21. See N.J.A.C. 10:52-1.16.

(b) For purposes of this rule, the following words and terms shall have the following meanings:

"Utilization control" means an approved program instituted, implemented and operated by or under the authorization of a utilization review organization (URO) which effectively safeguards against unnecessary or inappropriate Medicaid services and assesses the quality of those services to Medicaid and NJ FamilyCare fee-for-service beneficiaries.

(c) Under the Social Security Act, Section 1903(g) and (h), the Division is responsible for an effective program to control the utilization of services in hospitals. (See 42 CFR Part 456, Utilization Control, Subchapter B, C, and D). The required reviews of inpatient hospital services shall be con-

ducted by Utilization Review Organizations (UROs), which shall be reimbursed by the hospitals. Reimbursement rates shall include funding for these required reviews. Included under utilization control are: Certification and recertification of the need for inpatient care; medical, psychiatric and social evaluations; a plan of care established and periodically reviewed and evaluated by a physician; and a continuous program of utilization review under which the admission of each beneficiary is reviewed or screened. Hospital entitlement to Medicaid and NJ FamilyCare reimbursement for services rendered to a Medicaid or NJ FamilyCare fee-for-service beneficiary for each period of hospitalization shall be subject to the following requirements:

1. A physician shall certify, for each beneficiary or applicant, that inpatient services in the acute care or in the private psychiatric hospital are or were needed.

i. The certification shall be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid or NJ FamilyCare program authorizes payment.

ii. The certification shall be in writing and signed, or initialed, by a physician. The signature or initials are not acceptable if they are rubber stamped unless the physician has initialed the stamped signature. The physician shall date the certification on the date he or she signs it.

iii. The certification for any Medicaid or NJ FamilyCare fee-for-service patient shall be maintained in the beneficiary's medical record.

iv. Acceptable documentation for certification or recertification may be any of the following:

(1) A statement signed and dated, by the attending physician, staff physician, and/or consultant physician who has knowledge of the case, attesting that the beneficiary is in need of hospital care.

(2) Physician's orders which are signed and dated on admission and clearly attest to the need for hospital care.

(3) A medical evaluation which designates the services and which is signed and dated by a physician who has knowledge of the case.

(4) An admission review form signed and dated by an attending or staff physician who has knowledge of the case.

2. A physician shall recertify, for each Medicaid and NJ FamilyCare fee-for-service beneficiary or applicant, that inpatient services in a hospital are needed.

i. Recertification shall be made at least every 60 days after certification.

ii. The recertification shall be in writing, shall attest to the need for inpatient services, and shall be signed or initialed by a physician who has knowledge of the case.

iii. The physician shall date the recertification on the date that he or she signs it.

iv. The recertification shall demonstrate the need for the level and type of care that the beneficiary is receiving.

v. The recertification for any Medicaid or NJ FamilyCare fee-for-service beneficiary shall be maintained in the beneficiary's medical record.

vi. Acceptable documentation for recertification shall include any one of the following:

(1) A signed and dated statement by the physician who has knowledge of the case, attesting that continued care of a particular level or type is needed; or,

(2) Signed and dated orders by the physician who has knowledge of the case that clearly indicated that continued care is needed; or,

(3) Signed and dated progress notes by the physician who has knowledge of the case that clearly indicate that continued care is needed; or,

(4) Signed and dated reports that a physician might use in caring for the beneficiary that clearly indicate that continued care is needed; or,

(5) An admission certification or recertification form signed and dated by a physician who has knowledge of the case; or

(6) Utilization Review Committee (URC) minutes or form which indicate that the beneficiary's care was reviewed by a physician who had knowledge of the case and that continued care was needed. The physician's signature, with the date, shall be attached to the URC minutes or forms.

3. Any days billed by the hospital that are not in compliance with the certification/recertification requirements in (b)1 and 2 above shall be considered non-certified days and shall not be reimbursed by the Division.

i. Claims submitted that include non-certified days, (that is, "carved out" days or continued stay denials) as determined by the Division or its agents to affect billing, shall be billed "hard copy" and be accompanied by a certification of stay form.

(d) Before admission of an applicant or beneficiary to a private psychiatric hospital or before authorization for payment, the attending or staff physician shall make a medical evaluation of each applicant's or beneficiary's need for care in the hospital; and appropriate personnel shall make a psychiatric and social evaluation.

1. Each medical evaluation shall include the following:

- i. Diagnoses;
- ii. Summary of present medical findings;
- iii. Medical history;

iv. Mental and physical functional capacity;

v. Prognoses; and,

vi. A recommendation by a physician concerning admission to the mental hospital, or continued care in the hospital for individuals who apply for Medicaid or NJ FamilyCare while in the private psychiatric hospital.

(e) A plan of care shall be established prior to admission. Before admission of an applicant or beneficiary to an acute care general, special hospital, or private psychiatric hospital or before authorization for payment, a physician and other personnel in an acute care general and special hospital or the attending or staff physician in a private psychiatric hospital involved in the care of the individual shall establish a written plan of care for each Medicaid or NJ FamilyCare beneficiary or applicant.

1. The plan of care shall include:

i. Diagnoses, symptoms, complaints, and complications, indicating the need for admission;

ii. A description of the functional level of the individual;

iii. Objectives of the care (in private psychiatric hospitals only);

iv. Any order for diagnostic procedures; medications; treatments; consultations; restorative and rehabilitative services; patient activities; therapies; social services; diet; and, for private psychiatric hospitals only, special procedures for the health and safety of the patient;

v. Plans for continuing care, as appropriate; and, in a private psychiatric hospital, the review and modification of the plan of care; and,

vi. Plans for discharge, as appropriate.

2. Orders and activities shall be developed in accordance with the physician's instructions, (only for acute care general and/or special hospitals).

3. Orders and activities shall be reviewed and revised as appropriate by all personnel involved in the care of an individual (only for acute care general and/or special hospitals).

4. In acute care general and special hospitals, a physician and other personnel involved in the Medicaid or NJ FamilyCare beneficiary's case shall review each plan of care at least every 60 days.

5. In private psychiatric hospitals, for beneficiaries age 65 or over, the attending or staff physician and other personnel involved in the beneficiary's care shall review each plan of care at least every 90 days; and

6. Reports of evaluations and plans of care shall be entered in the applicant's or beneficiary's record, as follows:

- i. At the time of admission; or
- ii. If the individual is already in the facility, immediately upon completion of the evaluation or plan.

(f) For the Utilization Review (UR) Plan, each hospital shall evaluate the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. The UR includes review of the appropriateness of admissions, services ordered and provided, length of stay and discharge practices. (See 42 CFR 456.100 through 456.145, incorporated herein by reference.)

1. Upon admission of the patient to the hospital, a discharge plan shall be initiated and thereafter reviewed and updated regularly.

2. Any Medicaid or NJ FamilyCare-Plan A beneficiary or potential Medicaid or NJ FamilyCare-Plan A beneficiary who is considered for admission to a NF shall receive a preadmission screening in accordance with N.J.A.C. 10:52-1.11.

3. When an inpatient is to be discharged from the hospital and continuing medical care is required, either in another medical facility (such as a NF, special hospital) or by a community health agency (such as a home health agency), the hospital shall provide the facility or agency with a legible abstract or summary of the patient's care while hospitalized and recommendations for further medical care.

- i. This information shall be provided at the time of hospital discharge and shall be signed by the attending physician. The patient information transfer form (adopted by the New Jersey Hospital Association and the New Jersey Nursing Home Association) for a transfer from a hospital to a NF, or an equivalent transfer form, shall be used.

Recodified from N.J.A.C. 10:52-1.13 by R.1998 d.564, effective December 7, 1998.

See: 30 N.J.R. 1257(a), 30 N.J.R. 4225(a).

Former N.J.A.C. 10:52-1.14, Utilization control; inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals, recodified to N.J.A.C. 10:52-1.15.

Recodified from N.J.A.C. 10:52-1.14 and amended by R.2000 d.29, effective January 18, 2000.

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

Substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare fee-for-service throughout; in (b), deleted "Utilization Review Organization (URO)" definition; in (c), substituted a reference to Medicaid and NJ KidCare-Plan reimbursement for a reference to Medicaid payment in the introductory paragraph; in (d)1vi, inserted a reference to NJ KidCare; in (e), inserted references to NJ KidCare beneficiaries throughout; and in (f)2, inserted references to NJ KidCare-Plan A beneficiaries, and changed N.J.A.C. reference. Former N.J.A.C. 10:52-1.15, Utilization control; inpatient psychiatric services for recipients under 21 years of age in private psychiatric hospitals, recodified to N.J.A.C. 10:52-1.16. Amended by R.2005 d.214, effective July 5, 2005.

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

Rewrote the section.

10:52-1.16 Utilization control: inpatient psychiatric services for beneficiaries under 21 years of age in private psychiatric hospitals

(a) This section specifies the unique requirements for certification of the need for inpatient psychiatric services provided to beneficiaries under 21 years of age in private psychiatric hospitals. In accordance with Section 1905(a)16 and (h) of the Social Security Act, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the beneficiary's condition. This section also includes general requirements; certification of the need for services, which involves "active treatment" as defined in (c) below; requirements for the team certifying the need for services; and requirement for an individual plan of care. These requirements do not apply to an admission to a psychiatric unit of a general hospital. See N.J.A.C. 10:52-1.15 for requirements on utilization control in an acute care general hospital.

(b) This rule applies only to inpatient psychiatric services in an approved private psychiatric hospital for the treatment of children and youths before NJ FamilyCare-Children's Program beneficiaries reach age 19 and before the Medicaid beneficiary reaches age 21 or, if the Medicaid beneficiary was receiving the services immediately before he reached age 21, before the earlier of the following:

1. The date the beneficiary no longer requires the services; or
2. The date the beneficiary reaches age 22. (See 42 CFR 441.151).

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

1. "Active treatment" means implementation of a professionally developed and supervised plan of care, as described in (f) below, that is:

- i. Developed and implemented no later than 14 days after admission; and,
- ii. Designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time.

2. "Independent team" means a team that is not associated with the facility; for example, none of the members of the team has an employment or consultant relationship with the admitting facility. The independent team shall include a physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry and who has knowledge of the individual's clinical condition and situation.

3. "Interdisciplinary team," as described in Federal regulations in 42 CFR 441.156, is comprised of those employed by, or those who provide services to, Medicaid and NJ FamilyCare beneficiaries in the facility or pro-

gram, and include, at a minimum, either a Board-eligible or Board-certified psychiatrist; or a physician and a clinical psychologist who has a doctoral degree; or a physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a Master's degree in clinical psychology or who has been certified by the State psychological association; and one of the following:

- i. A psychiatric social worker;
 - ii. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;
 - iii. A psychologist who has a Master's degree in clinical psychology or who has been certified by the State or by the State psychological association; or,
 - iv. An occupational therapist who is licensed by the State in which the individual is practicing, if applicable, and who has specialized training or one year experience in treating mentally ill individuals.
4. "Plan of care" means a written plan developed for each beneficiary to improve the beneficiary's condition to the extent that the beneficiary no longer needs inpatient care.

(d) Certification of the need for services (see 42 CFR 441.152) shall be made by a team, either independent or interdisciplinary, as specified in (e) below, and shall include the following statements: The team shall certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;
2. Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. Services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that inpatient services would no longer be needed.

(e) The certification of the need for services, as stated in (d) above, shall be made by teams, in accordance with Federal regulations, 42 CFR 441.153 and specified as follows:

1. Certification for the admission of an individual who is a beneficiary when admitted to a facility or program shall be made by an independent team, as described in (c) above.
2. Certification for an inpatient applying for Medicaid or NJ FamilyCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (c) above.

3. Certification of an emergency admission of a beneficiary shall be made by the interdisciplinary team responsible for the plan of care, in accordance with Federal regulation, 42 CFR 441.156, and as described in (f)1 below.

(f) Within 14 days of admission to a private psychiatric hospital, or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or beneficiary to improve the beneficiary's condition to the extent that inpatient care no longer is necessary, in accordance with (e) above. (See 42 CFR 456.180 and 456.181.)

1. The plan of care shall:

i. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary's clinical condition and situation and reflects the beneficiary's need for inpatient psychiatric care;

ii. Be developed by a team of professionals as described in (g) below in consultation with the beneficiary, the beneficiary's parents, legal guardians or others in whose care he or she will be released after discharge;

iii. State treatment objectives;

iv. Prescribe an integrated program of therapies, activities and experiences designed to meet the beneficiary's treatment objectives; and

v. Include, at an appropriate time, post discharge plans and coordination of inpatient services with the partial discharge plan and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.

2. The plan shall be reviewed every 30 days by the team to:

i. Determine that services being provided are or were required on an inpatient basis; and,

ii. Recommend changes in the plan as indicated by the beneficiary's overall adjustments as an inpatient.

(g) Functions of the interdisciplinary team developing the individual plan of care are as follows:

1. The individual plan of care as described under 42 CFR 441.155, shall be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the psychiatric hospital.

2. Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of the following:

i. Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities;

- vi. Counseling regarding school/employment planning.

(d) Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with the Department of Health and Senior Services' "HealthStart Comprehensive Maternity Care Services Program Guidelines." Services shall be provided as follows:

1. Initial assessment of health educational needs, which shall include, but shall not be limited to, the patient's:

- i. Educational background;
- ii. Health education needs; and
- iii. Previous education and experience concerning pregnancy, birth and infant care;

2. Health education instruction, which shall be provided for all patients based on their identified health education needs shall include, at a minimum, the following:

- i. Normal course of pregnancy;
- ii. Fetal growth and development;
- iii. Warning signs, such as signs of pre-term labor, and identification of emergency situations;
- iv. Personal hygiene;
- v. Exercise and activity;
- vi. Childbirth preparation, including management of labor and delivery;
- vii. Preparation for hospital admission;
- viii. Substance, occupational and environmental hazards;
- ix. Need for continuing medical and dental care;
- x. Future family planning;
- xi. Parenting, basic infant care and development;
- xii. Availability of pediatric and family medical care in the community; and
- xiii. Normal postpartum physical and emotional changes.

3. Health education services, which shall include guidance in decision making and in the implementation of decisions concerning pregnancy, birth and infant care; and

4. Postpartum assessment of health education needs shall be conducted.

(e) One face-to-face preventive health care contact shall be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit in accordance with the Department of Health and Senior

Services' "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:

1. This contact shall include, but shall not be limited to:

- i. Review of the mother's health status;
- ii. Review of the infant's health status;
- iii. Review of mother/infant interaction;
- iv. Revision of the plan of care; and
- v. Provision of additional services, as indicated; and

2. The provider shall provide or arrange for one or more home visits for each high-risk patient in accordance with the Department of Health and Senior Services' "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(f) HealthStart maternity care providers shall utilize existing community services to enhance the maternity care services.

(g) HealthStart maternity care providers shall have written procedures which identify specific agencies or practitioners and criteria for referral of patients requiring services which are extensive, complex or expected to extend beyond the pregnancy. These procedures shall include, but shall not be limited to: nutrition and food supplementation services, substance abuse treatment facilities, mental health services, county/local social and welfare agencies, parenting and child care educational programs, future family planning services, fetal alcohol syndrome and AIDS counseling services.

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

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

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

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

Rewrote the section.

10:52-3.10 Professional staff requirements for HealthStart Comprehensive Maternity Care services

(a) All HealthStart comprehensive maternity care services shall be delivered through a team approach by qualified professionals.

(b) Physicians and certified nurse midwives shall be Medicaid and NJ FamilyCare fee-for-service providers and have obstetrical admitting privileges at a licensed maternity care facility.

(c) Case coordinators shall have, at a minimum, a license as a registered nurse; or a Bachelor's degree in social work, health or a behavioral science.

(d) Health professionals shall have a valid license to practice their professions, as required by the State of New Jersey.

(e) All other professionals, for whom no license to practice is required, shall meet generally accepted professional standards for qualification.

(f) Paraprofessionals shall be familiar with the local community, have knowledge or skills in maternal and child health services and shall be supervised by a health professional.

(g) Prenatal, delivery, and postpartum medical services shall be delivered by a physician or a certified nurse midwife.

(h) Nutrition, social-psychological and health education assessments and development of the plan of care shall be provided by appropriate professionals in each of the specialty areas, or by case coordinators or medical care professionals. If the nutrition or social-psychological assessment portion of the plan of care is provided by a case coordinator or medical care professional, then these portions shall be reviewed by a nutritionist or social worker, respectively.

(i) Nutrition and social-psychological basic counseling shall be provided by a case coordinator with at least one year of experience in providing services to maternity patients or by the appropriate specialist in each of the areas or by a registered nurse or obstetrical care provider.

(j) Short term specialized social-psychological and nutrition counseling services shall be provided by a social worker and nutritionist, respectively. The social worker and nutritionist shall be available on site during patient visits.

(k) There shall be adequate professional, paraprofessional and clerical staff to provide, in a timely manner, maternity care services as described herein which meet the needs of the patients.

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), inserted a reference to NJ KidCare—Plan A fee-for-service providers.

Amended by R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

Rewrote the section.

10:52-3.11 Records; documentation, confidentiality and informed consent requirements for HealthStart maternity care providers

(a) HealthStart maternity care providers shall have policies which protect patient confidentiality, provide for informed consent and document prenatal, labor, delivery and postpartum services in accordance with the Department of Health and Senior Services' "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(b) An individual record shall be maintained for each patient throughout the pregnancy.

(c) Each record shall be confidential and shall include at least the following: history and physical examination findings assessment, a plan of care, treatment services, laboratory reports, counseling and health instructions provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart services.

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

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

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

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

Rewrote (a); in (c), substituted "plan of care" for "Care Plan".

10:52-3.12 Standards for HealthStart pediatric care

(a) Pediatric care services shall be comprehensive, integrated and coordinated.

(b) HealthStart pediatric care providers shall be Medicaid and NJ FamilyCare fee-for-service providers and shall:

1. Directly provide preventive child health care, maintenance of complete patient history, outreach for preventive care, initiation of referrals for appropriate medical, educational, social, psychological and nutrition services, and follow-up of referrals and sick care;

2. Directly provide or arrange for non emergency room-based, 24-hour physician telephone access for eligible patients; and

3. Directly provide or arrange for sick care and emergency care.

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), inserted a reference to NJ KidCare—Plan A fee-for-service providers.

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), substituted "FamilyCare" for "KidCare-PlanA" preceding "fee-for-service" in the introductory paragraph, substituted "child health" for "well-child" following "Directly provide preventive" in 1, and substituted "for eligible" for "to" following "telephone access" in 2.

10:52-3.13 Professional requirements for HealthStart pediatric care providers

All HealthStart pediatric care providers shall be pediatricians or have a physician on staff who possesses a knowledge of pediatrics. This may be demonstrated by eligibility for board certification by the American Academy of Pediatrics, the American Osteopathic Board of Pediatrics, or by hospital admitting privileges in pediatrics.

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

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

Substituted "pediatricians" for "physicians" following "providers shall be" and substituted "American Academy of Pediatrics, the American Osteopathic Board of Pediatrics, or by hospital admitting privileges" for "American Academy of Pediatrics and/or by hospital admitting privileges" following "board certification by the".

10:52-3.14 Preventive care services provided by HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall provide preventive health visits in accordance with the recommended guidelines of the American Academy of Pediatrics. The schedule shall include a two-to four-week visit, two-month visit, four-month visit, six-month visit, nine-month visit, 12-month visit, 15-month visit, 18-month visit and 23-to 24-month visit. Each visit shall include, at a minimum, medical, family and social history, unclothed physical examination, developmental and nutritional assessment, vision and hearing screening, dental assessment, assessment of behavior and social environment, anticipatory guidance, age appropriate laboratory examinations, and immunizations. Referrals shall be made as appropriate.

(b) Each provider shall provide or arrange for sick care and 24-hour telephone physician access during non-office hours. If not directly provided by the HealthStart provider, sick care and 24-hour telephone access shall be provided for each child by a single designated provider via a documented agreement. Information on care given shall be communicated to the primary HealthStart pediatric care provider. Telephone access provided exclusively via emergency room staff shall not be permitted. Referral to the emergency room should occur only for emergency medical care or urgent care.

(c) Case coordination outreach and follow-up services shall include letter or telephone call reminders to the child's parent or guardian for preventive well-child visits and letter or telephone follow-up of missed appointments. Referrals for home visit services for follow-up shall be made when appropriate. For all referrals and follow-up visits, the provider shall document the completion of such referrals or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and to the referred agency shall be sent or made, encouraging the follow through of the referral. All of the activity shall be recorded on the patient's chart.

(d) All HealthStart pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational and nutrition services. This may include, but shall not be limited to: the Special Supplemental Food Program for Women, Infants and Children Program (WIC), the Division of Youth and Family Services, Special Child Health Services Case Management Units and Child Evaluation Centers, early intervention programs, county boards of social services, certified home health agencies, community mental health centers and local and county health departments.

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

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

In (d), substituted a reference to County Boards for a reference to County Welfare Agencies/Boards.

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

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

Rewrote the section.

10:52-3.15 Records; documentation, confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall have policies which protect patient confidentiality, provide for informed consent and document comprehensive care services.

(b) An individual record shall be maintained for each patient.

(c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, plan of care, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart pediatric services.

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

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

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

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

Rewrote (a); in (c), substituted "plan of care" for "Care Plan".

10:52-3.16 Reimbursement for HealthStart providers

(a) The HealthStart HCPCS procedure codes listed in this subchapter are governed by the same rules that appear in the HCPCS subchapter of each non-institutional provider services manual (Independent Clinic, Physician and the Nurse Midwifery Services Chapters). The maximum fee allowance schedule and reimbursement requirements for HCPCS HealthStart Maternity Codes (Medical Care and Health Support Services) and HCPCS HealthStart Pediatric Codes are listed under N.J.A.C. 10:66-6.

(b) A hospital outpatient department (OPD) which is a HealthStart Provider shall use the procedure for OPD billing (UB-92 claim form), contained in this chapter; except for the following services:

1. HealthStart Health Support Services (W9040 through W9043), which shall be billed on the CMS 1500 claim form, using the Independent Clinic billing number; and

2. HealthStart pediatric continuity of care services (W9070), which shall be billed on the MC-19 form, EPSDT Referral Report.

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 HCFA 1500 claim forms for a reference to 1500 N.J. claim forms in 1, and substituted a reference to EPSDT Referral Report for a reference to Report and Claim for EPSDT/Health—Start Screening and Related Procedures.

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), deleted "policies and" preceding "rules that appear" and amended the N.J.A.C. reference; in (b), rewrote the introductory

paragraph and substituted "CMS" for "HCFA" preceding "1500 claim form" in 1.

10:52-3.17 HealthStart Maternity Care billing code requirements

(a) HealthStart Maternity Care billing code requirements shall be as follows:

1. Separate reimbursement shall be available for maternity medical care services and maternity health support services.

2. Maternity medical care services shall be billed as a total obstetrical package, when applicable, but may be billed as separate procedures.

3. The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart maternity medical or health support service.

4. The modifier "WM" in the HCPCS lists of codes (W9025 through W9030) refers to those services provided by certified nurse midwives who shall include the modifier at the end of each code. HCPCS codes for health support services do not require the "WM" modifier on HCPCS codes W9040 and W9043.

5. Laboratory and other diagnostic procedures and all necessary medical consultations shall be eligible for separate reimbursement.

(b) HealthStart maternity medical care procedure codes are provided in N.J.A.C. 10:66-6, the Healthcare Common Procedure Coding System (HCPCS) for Independent Clinic Services.

Amended by R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

In (a), substituted "applicable" for "feasible" preceding ", but may be billed" in 2; rewrote (b).

SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

10:52-4.1 Basis of payment; acute general hospitals reimbursed under the Diagnosis Related Groups (DRG) system—inpatient services

The Division will reimburse acute care general hospitals for inpatient services based upon rates determined under N.J.A.C. 10:52-5 through 8, except for distinct units of acute care general hospitals. For reimbursement methodology for distinct units of acute care general hospitals, see N.J.A.C. 10:52-4.2(e).

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. reference.

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

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

Amended the final N.J.A.C. reference.

10:52-4.2 Basis of payment; special hospitals (Classification A and B), private and governmental psychiatric hospitals and distinct (excluded units) of acute general hospitals—inpatient services

(a) The Division will reimburse special hospitals (Classification A) (acute and short term special hospitals) and Classification B (Rehabilitation hospitals), excluding specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services, effective for the 2002 rate year, in accordance with P.L. 2001, c.393, section 5, for inpatient services (including the interim and final settlement), in accordance with Medicare principles of reimbursement (see 42 CFR 413).

(b) Specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services will be reimbursed a prospective per diem rate. The initial prospective per diem rate, effective for the 2002 rate year, shall be based on the total Medicaid inpatient costs divided by the total Medicaid days for Fiscal Year 1999, using the hospital's first finalized audited Fiscal Year 1999 cost report. If the hospital has been in operation less than two full years prior to Fiscal Year 1999, the prospective per diem rate shall be set using the hospital's first finalized audited Fiscal Year 2000 cost report. The initial prospective rate shall be increased annually by an economic factor, as specified in N.J.A.C. 10:52-5.13(a).

1. A hospital may request a change to its prospective per diem rate as either an adjustment to its base year costs in accordance with 42 CFR 413.40(g), or assignment of a new base year in accordance with 42 CFR 413.40(i).

2. The hospital's request shall be received within 180 days from the end of the fiscal year for which the adjustment or new base was requested, and shall include all supporting documentation.

3. The Division may grant an interim adjustment, subject to final adjudication of the hospital's request. The Division's final determination shall be made based upon financial data from the hospital's audited cost report for the year for which the adjustment or new base year was requested.

4. The Division shall issue a written determination with an explanation for each request for an adjustment or new base year.

i. Separate unit rates shall be reimbursed for the following service categories as defined in N.J.A.C. 10:52 and 10:52A:

(1) Adult acute partial hospital services shall be billed on an hourly basis using revenue code 913. At least two hours per day of services shall be billed, but not more than five hours. The hourly unit rate is \$65.00. When revenue code 913 is billed, no other outpatient psychiatric revenue code can be billed on the same date of service.

(2) Partial hospital services shall be billed on an hourly basis using revenue code 912. At least two hours per day shall be billed, but not more than five hours. The hourly unit rate is \$35.00. When revenue code 912 is billed, no other outpatient psychiatric revenue code can be billed on the same date of service.

(3) Individual outpatient hospital psychiatric services shall be billed on a unit basis of 30 minutes using revenue code 914. The daily billing limit is two units per day. The half hour unit rate is \$40.00.

(4) Initial evaluations shall be billed on a unit basis of 30 minutes using revenue code 918. The daily billing limit is four units per day. The half hour unit rate is \$50.00.

(5) Group outpatient hospital psychiatric services shall be billed on an hourly basis using revenue code 915. The billing limit is three hours per week. The hourly unit rate is \$30.00.

(6) Medication monitoring and medication management shall be billed on a unit basis of 15 minutes using revenue code 919. The daily billing limit shall be two units per day. The 15 minutes unit rate is \$34.00.

ii. Costs related to all outpatient psychiatric services for individuals 22 years of age and over shall be excluded from outpatient cost settlements. Hospitals shall maintain a separate cost center on the Medicare cost report for all outpatient psychiatric services, regardless of the age of the individuals treated. Hospitals shall report all psychiatric outpatient costs, charges and statistics in this separate cost center.

9. All outpatient psychiatric services provided to youth and young adults under age 21 shall be paid fee-for-service for the following service categories at the lower of charges or prospective unit rates:

i. Youth and young adult partial hospital services shall be billed on an hourly basis using revenue code 913. The rate is \$73.00 per hour. A claim for such services shall not be billed or reimbursed for any day on which less than two hours of such services are provided to the beneficiary. A claim shall not be billed or reimbursed for more than five hours of such services per day provided to the beneficiary. When revenue code 913

is billed, no other outpatient psychiatric revenue code can be billed for the same day of service.

ii. Individual outpatient hospital psychiatric services for youth or young adults shall be billed on a unit basis of 30 minutes using revenue code 914. The daily billing limit is three units per day, to include family conferencing, which can be up to 1.5 hours per day. The half hour rate is \$50.00. Individual sessions where the youth is the sole participant should not exceed two units per days, unless there are extenuating circumstances that shall be documented in the file prior to the submission of the claim for reimbursement.

iii. Evaluations for youth and young adults shall be billed on a unit basis of 30 minutes using revenue code 918. The daily billing unit is four units per day. The half hour unit rate is \$62.50. Reimbursement is available if the evaluation is performed by a clinically licensed mental health professional and can include specialized assessments, as well as evaluations for admission into a partial hospital program for youth or young adults.

iv. Group outpatient hospital psychiatric services for youth or young adults shall be billed on an hourly basis using revenue code 915. The billing limit is three hours per week. The hourly unit rate is \$30.00.

v. Medication management for youth or young adults shall be billed on a unit basis of 15 minutes using revenue code 919. The daily billing limit shall be two units per day. The 15-minute unit rate is \$42.00.

(c) Emergency room visits for treatment of conditions that are not the responsibility of an HMO or for Medicaid or NJ FamilyCare fee-for-service beneficiaries who are not admitted as inpatients shall be coded by the hospital as requiring primary care or non-primary care.

1. Primary care is defined as those categories described in the Physicians' Current Procedural Terminology (CPT) as either minimal, brief, or limited service.

2. Non-primary care shall be defined as those categories described in the Physicians' Current Procedural Terminology (CPT), 1994, as amended and supplemented, as either intermediate, extended, or comprehensive service.

3. Hospitals shall not refuse to provide emergency room services to any Medicaid beneficiary for the reason that such beneficiary does not require services on an emergency basis.

4. The cost of emergency room services for a Medicaid/NJ FamilyCare fee-for-service beneficiary for the treatment of a condition that is not the responsibility of an HMO when the beneficiary is admitted as an inpatient shall be allocated to the inpatient rates and shall not be reimbursed through the outpatient hospital's reimbursement methodology, as stated above.

Amended by R.1996 d.479, effective October 7, 1996.

See: 28 N.J.R. 3221(b), 28 N.J.R. 4479(b).

Amended by R.1997 d.396, effective September 15, 1997.

See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).

Rewrote (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 (a), substituted references to governmental psychiatric hospitals for references to psychiatric hospitals and inserted references to distinct units of acute care hospitals throughout, and changed N.J.A.C. reference in the introductory paragraph; in (b)1, substituted a reference to fee-for-service schedules for a reference to fee-for-service in the introductory paragraph, changed N.J.A.C. reference in i, and substituted a reference to Medicaid NJ KidCare for a reference to Medicaid in ii(1); in (b)2i, substituted a reference to Medicaid NJ KidCare fee-for-service reimbursement for a reference to Medicaid reimbursement, and changed N.J.A.C. reference; in (b)6i, inserted a reference to NJ KidCare fee-for-service; and rewrote (c).

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

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

Rewrote the section.

Amended by R.2007 d.59, effective February 5, 2007.

See: 38 N.J.R. 4359(a), 39 N.J.R. 456(a).

In the introductory paragraph of (b), deleted "and the" preceding "Medicare" and substituted "and all outpatient psychiatric services for individuals 22 years of age and over" for a comma following "amounts"; and added (b)8.

Amended by R.2008 d.375, effective December 15, 2008.

See: 40 N.J.R. 4667(a), 40 N.J.R. 6966(b).

In the introductory paragraph of (b), deleted "for individuals 22 years of age and over" preceding "are excluded"; in (b)8, substituted "21" for "22"; and added (b)9.

10:52-4.4 Basis of payment and appeal procedure; out-of-State hospital services

(a) The Division shall reimburse an out-of-State approved hospital (see N.J.A.C. 10:52-1.2, Definitions) for providing inpatient and outpatient hospital services to New Jersey Medicaid or NJ FamilyCare beneficiaries if the hospital meets the requirements of the Division and the services are prior authorized pursuant to N.J.A.C. 10:52-1.10. Reimbursement of inpatient hospital services is outlined in (b) through (c) below, and for outpatient services is outlined in (d) below. See (e) below for the procedure for rate appeals for out-of-State hospitals.

(b) Reimbursement for inpatient hospital services for an out-of-State hospital participating in the New Jersey Medicaid or NJ FamilyCare program shall be based on the following criteria:

1. All rates in effect at the time the service is rendered shall be considered final rates by the State. Reimbursement shall be at 100 percent of the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located except as specified in (b)2 and (c) below. The Division shall not reimburse out-of-State hospitals for disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located.

2. An out-of-State hospital should provide official documentation of the Medicaid rate that has been established

by the State Medicaid agency in the state in which the hospital is located.

- i. An example of acceptable documentation is a copy of the letter sent by the State Medicaid Agency to the hospital specifying the Medicaid rate. The purpose of this information is to facilitate claims processing.

- (c) In the event an out-of-State hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with the State Medicaid agency, the hospital must enter into a negotiated rate with the Division at the time of enrollment for inpatient hospital services. The rate that is established between the hospital and the Division may be reviewed periodically thereafter.

1. Reimbursement for out-of-State inpatient hospital services for organ transplantation and procurement provided to a Medicaid or NJ FamilyCare beneficiary who has been determined to be in need of, and approved for, a kidney, heart, heart-lung, liver, bone marrow transplant, or other selected medically necessary organ transplants, except for those transplants categorized as experimental because of a life threatening situation, shall be at a rate negotiated between the New Jersey Medicaid/NJ FamilyCare program and the hospital performing the organ transplant.

2. Cornea transplants, although not life-threatening, shall be reimbursed as any other out-of-State transplant service.

- (d) Reimbursement for outpatient hospital services in an out-of-State approved hospital is based on the rate of reasonable covered charges (subject to a percentage reduction based upon the cost-to-charge ratio) approved by the State Medicaid Agency in the state in which the hospital is located if the hospital participates in the State's Medicaid program, or if the hospital does not participate in the State's Medicaid program, the rate negotiated by the Division with the hospital.

- (e) In addition to the provisions of N.J.A.C. 10:52-9.1(c) and (d), the following rate appeal procedure shall be followed for a rate appeal filed by an out-of-State hospital:

1. If an out-of-State hospital wishes to file an appeal concerning issues related to the rate of reimbursement, the appeal shall be filed by the hospital, in writing, to the following address within 20 calendar days after the filing of a rate appeal by the hospital to the State Medicaid agency in the state in which the hospital is located.

Division of Medical Assistance and Health
Services
Office of Administrative and Financial Services
PO Box 712, Mail Code #44
Trenton, New Jersey 08625-0712

2. The following limitations shall apply to the rate appeal procedure in (e)1 above.

i. The hospital shall submit with its rate appeal to the Division all appropriate documentation demonstrating that an appeal was filed with the State Medicaid agency in the state in which the hospital is located and the date that the appeal was filed.

ii. If the hospital did not file a timely appeal in the state in which it is located, the payment made by the New Jersey Medicaid or NJ FamilyCare program shall be considered the final payment.

Amended by R.1998 d.352, effective July 20, 1998.

See: 30 N.J.R. 1258(a), 30 N.J.R. 2653(a).

In (a), substituted "NJ KidCare beneficiaries" for "recipients", changed N.J.A.C. references, and added a new last sentence; rewrote (b); and added a new (e).

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 (e), changed N.J.A.C. references; and in (c), substituted a reference to Medicaid and NJ KidCare beneficiaries for a reference to Medicaid recipients and substituted a reference to the Medicaid/NJ KidCare program for a reference to the Medicaid program in 1.

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), amended the N.J.A.C. reference; in (c), designated the former last sentence of 1 as 2; substituted "FamilyCare" for "KidCare" throughout.

10:52-4.5 Reimbursement for third-party claims

On claims for hospital services rendered to Medicaid or NJ FamilyCare beneficiaries for services provided that are not the responsibility of an HMO and who are also covered by another form of health insurance, the Division shall pay the difference between the insurer's payment amount and that of Medicaid/NJ FamilyCare for covered services. (See N.J.A.C. 10:49-7.3.)

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

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

Rewrote the section.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

10:52-4.6 Medicare/Medicaid or Medicare/NJ FamilyCare claims

(a) Some patients may be covered under both Medicare and Medicaid or Medicare and NJ FamilyCare. When the Medicaid or NJ FamilyCare beneficiary is covered under both programs, Item 57 on the hospital claim form shall be completed showing the Medicaid or NJ FamilyCare Eligibility Identification Number.

(b) Reimbursement of the deductible and coinsurance for inpatient and outpatient services for Medicaid or NJ FamilyCare beneficiaries having both Medicare and Medicaid coverage shall be limited to the unsatisfied deductible and coinsurance.

(c) Where benefits have been exhausted under Medicare, the charges to be billed to the Medicaid/NJ FamilyCare Program must be itemized for the Medicare non-covered services and the Medicaid or NJ FamilyCare Eligibility Identification Number, including Person Number, must be shown on the hospital claim form.

(d) Where prior authorization is required for Medicaid/NJ FamilyCare program purposes, it shall be obtained and shall be submitted with the UB-92 claim form.

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

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

Rewrote the section.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

10:52-4.7 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D fee-for-service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services are \$5.00 a visit for outpatient clinic visits and \$10.00 for an emergency room visit that does not result in an inpatient hospital stay.

(c) Hospitals are required to collect the personal contribution to care for the above mentioned NJ FamilyCare-Plan C services if the NJ FamilyCare Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ FamilyCare form which indicates that the beneficiary has reached their cost share limit and no further personal contributions to care are required, until further notice. Personal contribution to care charges cannot be waived.

(d) Under NJ FamilyCare-Plan D, copayments in the amounts indicated below shall be collected by the hospital for the services as follows:

1. A \$5.00 copayment per visit shall be required for the following services:

- i. Outpatient rehabilitation services, including physical therapy, occupational therapy and speech therapy;
- ii. Hospital outpatient department visits and diagnostic testing;

(1) For prenatal care, the \$5.00 copayment shall apply only to the first visit;

2. A \$25.00 copayment per visit shall be required for outpatient mental health visits; and

3. A \$35.00 copayment per visit shall be required for outpatient emergency services including services provided in an outpatient hospital department or an urgent care facility.

- i. No copayment shall be required if the beneficiary was referred to the emergency room by his or her primary care provider for services that should have been rendered in the primary care physician's office or if the beneficiary is admitted into the hospital.

4. No copayment shall be charged for the following services:

- i. Outpatient surgery;
 - ii. Inpatient hospital services;
 - iii. Inpatient mental health services;
 - iv. Inpatient substance abuse detoxification services;
- or
- v. Skilled nursing facility services.

(e) Hospitals shall collect the copayment specified in (d) above except for those situations outlined in (f) below. Copayments shall not be waived.

(f) Hospitals shall not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, including well child visits and age-appropriate immunizations; for lead screenings and treatment, or for preventive dental services provided to children under the age of 12.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:52-4.7, Medicaid settlement, recodified to N.J.A.C. 10:52-4.8.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

In (a), added reference to copayments for NJ KidCare-Plan D; added (d) through (f).

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

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

Substituted "FamilyCare" for "KidCare" throughout.

10:52-4.8 Settlement for Medicaid/NJ FamilyCare fee-for-service services

(a) The New Jersey Medicaid settlement agent for New Jersey acute care general (excluding inpatient services), special, rehabilitation, and private psychiatric and county governmental psychiatric hospitals shall determine the amount of disbursements, recoupments, and/or changes in per diem amounts and outpatient percentages, as applicable. The settlement agent shall inform the hospital and the Division of Medical Assistance and Health Services (Division/DMAHS) of the results of their review. If the settlement agent's review is accepted, DMAHS, through its fiscal agent for claims processing, shall perform the following processes:

1. For disbursements, payment shall be made to the hospital for the full amount due within 30 days from the date of settlement agent's letter.

2. The fiscal agent shall begin recoupment for the full amount of the overpayment 30 days after the date the Division receives the settlement agent's overpayment notification by withholding the Medicaid/NJ FamilyCare fee-for-service payments to the hospital.

3. If the withholding of the New Jersey Medicaid/NJ FamilyCare fee-for-service payments is not acceptable to the hospital, the hospital must submit, prior to the end of the 30-day period, a proposed repayment schedule to the Division. For a repayment schedule in excess of three months, documentation (as specified in Medicare Provider Reimbursement Manual 13-2, Section 2223, Establishing Extended Repayment) shall be submitted. If an approvable repayment schedule is not received by the Division, the withholding of Medicaid/NJ FamilyCare fee-for-service payments shall be implemented to begin recoupment.

4. The proposed repayment plans should be submitted directly to the following address:

Office of Hospital Reimbursement
Division of Medical Assistance and Health Services
PO Box 712, Mail Code #44
Trenton, New Jersey 08625-0712

5. Interest shall be charged at the maximum legal rate as of the date of the repayment agreement or 30 days from the date of the settlement agent letter to the Division, whichever is sooner.

Recodified from N.J.A.C. 10:52-4.7 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

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).

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

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

Rewrote the section.

SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

10:52-5.1 Derivation of Preliminary Cost Base

For general acute care hospitals, the Division of Medical Assistance and Health Services (hereafter referred to as the Division or its designee), on or before March 12, 1993 and on or before January 31 of each subsequent rate year shall implement a rate. For hospitals with a fiscal year of January 1, the rate year will be the calendar year. For hospitals on a fiscal year beginning other than January 1, but before July 1, the rate year will be the year the fiscal year begins and for hospitals on a fiscal year beginning between July 1 and December 31, the rate year will be the year the fiscal year ends.

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

10:52-5.2 Uniform Reporting: Current costs

Hospitals shall be required to submit reports as required in N.J.A.C. 8:31B-4. The Director shall review the actual costs for the institutions as reported in accordance with the Financial Reporting Principles and Concepts (Subchapter 6). The review will be performed according to the methodology outlined below. Costs, so reported, shall be subject to revision due to subsequent audits.

10:52-5.3 Costs per case

Direct and indirect care costs shall be allocated to the inpatient and outpatient services. Direct and indirect costs allocated to inpatient services shall be used to determine inpatient rates per case according to the patient diagnosis. This cost finding process is described in N.J.A.C. 10:52-5.7 through 5.11.

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.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. reference.
Amended by R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).
Amended the N.J.A.C. reference.

10:52-5.4 Development of standards

(a) For services provided prior to October 1, 1996, the Director shall develop standard reimbursement amounts for each Diagnosis Related Group (DRG) based on the median cost plus five percent per case for Medicaid recipients. The standards shall be adjusted to account for significant differences in teaching responsibilities and in labor market areas. These standards are developed according to criteria set forth in N.J.A.C. 10:52-5.11 through 5.17. Standards so developed and issued for a rate year shall remain unaffected and no adjustments, modifications or changes to the standards shall be made except as referenced in N.J.A.C. 10:52-5.10.

(b) Effective for services provided on or after October 1, 1996, the Director shall develop standard reimbursement amounts for each DRG based on the median cost per case for Medicaid and NJ FamilyCare fee-for-service beneficiaries. The standards shall be adjusted to account for significant differences in labor market areas. These standards are developed according to criteria set forth in N.J.A.C. 10:52-5.11 through 5.17. Standards so developed and issued for a rate year shall remain unaffected and no adjustments, modifications or changes to the standards shall be made except as referenced in N.J.A.C. 10:52-5.10.

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).

In (a), inserted text "For services provided prior to October 1, 1996"; and added (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; and in (b), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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), inserted "(DRG)" following "Diagnosis Related Group" and amended the N.J.A.C. references in the third and fourth sentences; in (b), substituted "DRG" for "Diagnosis Related Group" preceding "based on the median cost", substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiaries", inserted "forth" following "criteria set", and amended the N.J.A.C. references in the third and fourth sentences.

10:52-5.5 Current Cost Base

(a) A hospital's Current Cost Base is defined as the actual costs and revenues as identified in the Financial Elements in the base reporting period as recognized by the Division for purposes of rate setting.

(b) The Current Cost Base is used to develop the Preliminary Cost Base (PCB) and Schedule of Rates through:

1. Determination of the costs of Medicaid patients treated in the 1988 base year;
2. Identification of fixed and variable components of the Preliminary Cost Base;
3. Calculation of the economic factor cost component as defined in N.J.A.C. 10:52-5.13(a);
4. Calculation of the technology factor as described in N.J.A.C. 10:52-5.13(b);
5. The costs used to set rates for the rate year will be based on 1988 costs.

(c) A hospital's actual cost reports cannot be substituted or rearranged once the Director has determined that the actual cost submission is suitable for entry into the data base.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).
Recodified from N.J.A.C. 10:52-5.9 and amended by R.2000 d.29, effective January 18, 2000.

i. Hospitals who receive funding from the Hospital Relief Subsidy Fund shall only be eligible for a payment from this fund if recognized by the Division of Mental Health Services as a Short Term Care Facility (STCF) or a Child Community Inpatient Serviced STCF and CCIS shall be based upon its distribution of beds for these services times a projection of the cost of providing the service in a state facility. Any hospital adding these beds will be eligible for payments from this fund. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year but may be redistributed on a quarterly basis as new beds are added or removed from service, at the discretion of DMHS.

ii. Hospitals who are not a STCF or CCIS, but which are under contract with the Division of Mental Health Services shall receive an allocation of funds based upon the percentage of services provided by the hospital as a percentage of all services provided by all hospitals. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year but may be redistributed on a quarterly basis as new beds are added or removed from service, at the discretion of DMHS.

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

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

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

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

Petition for Rulemaking.

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

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

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

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

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

Petition for Rulemaking.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recodified from 10:52-8.2(a)5 and amended by R.2000 d.29, effective January 18, 2000.

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

Made internal designation changes throughout.

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), inserted "(DMHS)" following "Division of Mental Health Services" in the introductory paragraph, substituted "STCF" for "STF" preceding "and CCIS" and rewrote the last sentence in li, and rewrote the last sentence in lii.

10:52-13.7 Calculation and distribution of disproportionate share hospital (DSH) payments as a result of a hospital closure; purpose and procedure

(a) The purpose of this rule is to provide a procedure to redistribute disproportionate share hospital (DSH) payments to provide for the patients who would have been served by a closed general hospital, had the hospital remained open. Hospital closure is defined as cessation of operations as a general hospital facility. When a hospital closes, DSH payments to the closed hospital will immediately cease. The DSH payments that would have gone to that hospital, had that hospital not closed, shall be reallocated and distributed to eligible hospitals, in accordance with Federal and State laws, rules and regulations. The eligible hospitals that are serving or are expected to serve the patients who would have gone to the closed hospital will receive the closed hospital's remaining allocation for the State fiscal year in which the hospital closed. This rule shall be applied to specify the eligible hospitals and the calculation and distribution of the closed hospital's DSH payments. Subsections (b), (c) and (d) below address the charity care subsidy allocated pursuant to N.J.S.A. 26:2H-18.59(e), and any supplemental charity care subsidy allocated pursuant to any appropriations act that may provide for supplemental charity care subsidies; subsection (e) below addresses the Hospital Relief Subsidy Fund.

(b) To be eligible for a portion of the closed hospital's charity care allocation and/or supplemental charity care allocation, a hospital shall satisfy all three of the following criteria:

1. The hospital shall have received a charity care subsidy allocation, under the methodology set forth in N.J.S.A. 26:2H-18.59e, and/or a supplemental charity care subsidy allocation, under the methodology set forth in any appropriations act that may provide for supplemental charity care subsidies, during the State Fiscal Year in which the closed hospital ceased operations as a general hospital;

2. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined, based on the most recent available complete calendar year UB data maintained by the Department of Health and Senior Services (DHSS), as follows:
 - i. Rank zip codes from highest to lowest, based on the percentage of total admissions drawn from each zip code by the closed hospital; and
 - ii. Include the ranked zip codes in the closed hospital's market area (beginning with the highest-ranked zip code) until the percentage of admissions, when added together, constitutes 75 percent of the closed hospital's total admissions; and

3. The hospital shall demonstrate that it has a market share of 25 percent or more of admissions from the market area that the closed hospital served, as defined in (b)2 above. This determination shall likewise be made based on the most recent available complete calendar year UB data maintained by DHSS, but the closed hospital's UB data will not be included in making this determination.

(c) The available charity care and/or supplemental charity care funds to be reallocated, with respect to the State fiscal year in which the hospital closed, shall be distributed among eligible hospitals based upon each eligible hospital's market share of admissions as a percentage of the market share of admissions of all eligible hospitals, as determined from the results of the calculations in (b)3 above.

(d) In each year after the hospital closed in which the source hospital data precedes the year of closure and includes at least six months of hospital charity care claims data, a charity care and/or supplemental charity care allocation that would have gone to the closed hospital shall be initially calculated. Then the reallocation of the closed hospital's calculated charity care and/or supplemental charity care allocation shall be calculated and distributed to eligible hospitals, using the methodology set forth in (b) above to identify eligible hospitals. The available charity care and/or supplemental charity care funds to be reallocated under this subsection shall be distributed among eligible hospitals based upon each eligible hospital's market share of admissions as a percentage of the market share of admissions of all eligible hospitals, as determined from the results of the calculations pursuant to (b) above.

(e) In each year after the hospital closed in which the source hospital data precedes the year of closure and includes at least six months of hospital data, a Hospital Relief Subsidy Fund (HRSF) allocation that would have gone to the closed hospital shall be initially calculated. Then the reallocation of the closed hospital's calculated HRSF allocation shall be calculated and distributed to eligible DSHs using the same data as was used for the original allocation, with the exception of market share admission data, which shall be taken from the most recent available UB data in the following manner:

1. To be eligible to receive a portion of the closed hospital's HRSF allocation a hospital shall satisfy all three of the following independent criteria:

i. The hospital shall have received a HRSF allocation, under the methodology set forth in N.J.A.C. 10:52-13.5, during the State fiscal year in which the closed hospital ceased operations as a general hospital;

ii. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined as defined in (b)2 above; and

iii. The hospital shall have a market share of 25 percent or more of problem-billed admissions. The market share problem-billed admissions shall be based on the number of admissions from the same market area, identified by zip code that the closed hospital served as defined in (d)1ii above, for the problem-billed categories specified in N.J.A.C. 10:52-8.2(a)4i(2)(A).

2. The available HRSF payments to be reallocated shall be distributed among eligible hospitals based upon each eligible hospital's market share of problem-billed admissions as a percentage of the market share of problem-billed admissions of all eligible hospitals, as determined from the results of the calculations in (d)1iii above. The reallocated funds shall be distributed on a monthly basis.

(f) Notwithstanding any other provision of this rule, if the Commissioner of Health and Senior Services and the Commissioner of Human Services agree that, in the case of closure of a hospital eligible to receive DSH funds, maintaining beneficiary access to health care services requires an alternative distribution of a closed hospital's DSH funds, they will do so in accordance with this subsection. Factors the Commissioners will consider in determining whether an alternative distribution will be made shall include, but shall not be limited to, the following:

1. Maintenance of continued timely access to hospital-based services for persons eligible to participate in the New Jersey Hospital Care Payment Assistance Program and/or persons receiving services in the Hospital Relief Subsidy Fund categories; or

2. Continued operation in the same or adjoining municipality as the closed hospital of an acute care hospital, eligible to receive Disproportionate Share payments, belonging to the same system as the closed hospital and serving substantially the same eligible population.

New Rule, R.1998 d.60, effective January 20, 1998.

See: 29 N.J.R. 4376(a), 30 N.J.R. 388(a).

Recodified from 10:52-8.3 and amended by R.2000 d.29, effective January 18, 2000.

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

In (c)1ii, changed N.J.A.C. reference.

Amended by R.2001 d.302, effective August 20, 2001.

See: 33 N.J.R. 2064(a), 33 N.J.R. 2812(a).

Rewrote the section.

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement text will be distributed to providers and copies will be filed with the Office of Administrative Law. The Fiscal Agent Billing Supplement may be reviewed and downloaded by accessing the following website: www.njmmis.com. For a paper copy of the Fiscal Agent Billing Supplement, write to:

UNISYS
PO Box 4801
Trenton, New Jersey 08619-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

Amended by R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

Designated former Appendix as Appendix A, substituted "text" for "pages" preceding "will be distributed", inserted the sentence containing the website and inserted "paper" preceding "copy" in the last sentence of the Agency Note.

APPENDIX B
EMC MANUAL

AGENCY NOTE: The Electronic Media Claims (EMC) Manual is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the EMC Manual, replacement text will be distributed to providers and copies will be filed with the Office of Administrative Law. The EMC Manual may be reviewed and downloaded by accessing the following website: www.njmmis.com. For a paper copy of the EMC Manual, write to:

Unisys
PO Box 4801
Trenton, NJ 08619-4801

New Rule, R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).