CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D–6a(1), 30:4D–7, 7a, b, c, and e; 30:4D–12, P.L. 1992, c.160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 447.251, 253.

Source and Effective Date

R.1995 d.123, effective February 3, 1995.
See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Executive Order No. 66(1978) Expiration Date

Chapter 52, Hospital Services Manual, expires on February 3, 2000.

Chapter Historical Note

Chapter 52, originally Manual for Hospital Services, became effective with Subchapter 1, Coverage, and Subchapter 2, Admission and Billing Procedures, 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 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 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 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, but operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a). Pursuant to P.L. 1992, c. 160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 C.F.R. 447.251, 253 and the authority cited above 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. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1995 d.123. See: Source and Effective Date. As a part of R.1995 d.123, Chapter 52 was retitled Hospital Services Manual; existing Subchapters 1 through 4 were repealed, and new Subchapters 1 through 4 were adopted, effective April 17, 1995; and Subchapter 10 was adopted as new rules, effective April 17, 1995. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:52–1.1 Purpose and scope

This chapter of the Hospital Services Manual outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid recipients. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and private psychiatric hospitals, unless specifically indicated otherwise.

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

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.

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

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

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

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

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

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

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid recipients under 21 years of age for the purpose of assessing a recipient's health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

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

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

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

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

"Hospital" means an institution which is primarily engaged in providing the following services to inpatients, by or under the supervision of physicians:

1. Diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or,

2. Rehabilitative services for the rehabilitation of injured, disabled, or sick persons; and that

3. Maintains clinical records on all patients;

4. Has by-laws in effect with respect to its staff of physicians;

5. Requires every patient to be under the care of a physician;

6. Provides 24–hour nursing services rendered or supervised by a registered professional nurse, and has a registered professional nurse or licensed practical nurse on duty at all times;

7. Has in effect a hospital utilization review plan that meets the requirement of the law (Sec. 1861(K) of the Social Security Act); and has in place a discharge planning process that meets the requirements of the law (Sec. 1861(ee)) of the Social Security Act;

8. Is licensed as a hospital in the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located, or approved by the agency of the state or locality responsible for licensing hospitals meeting the standards established for such licensing;

9. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of health and safety of individuals who furnished services in the institution; and

10. For the purposes of N.J.A.C. 10:52–1.2A only, is where the main inpatient hospital services are located.

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

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid provider);

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

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

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

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

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

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

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

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

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

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

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

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

1. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;

2. Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation as a hospital or rehabilitation facility; and/or

4. An explanation concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure;

5. An offer to answer any inquiries concerning the procedures; and

6. An instruction that the individual is free to withhold or withdraw his or her consent to the procedure at any time prior to the sterilization without prejudicing his or her future care without loss of other project or program benefits to which the patient might otherwise be entitled;

7. The documentation referred to in this subsection must meet all applicable State and Federal requirements, and should be bilingual as necessary. (See N.J.A.C. 10:52–2.12 Sterilization).

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

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

"Inpatient Hospital Services" means services that:

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

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

3. Are furnished in an institution that:

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

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

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

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

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

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

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

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

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

"Outpatient hospital services" means medically necessary items or services (preventive, diagnostic, rehabilitative, or palliative) provided to an outpatient by or under the direction of a physician or dentist, except for the medical supervision of nurse midwife services; and/or by private inpatient psychiatric facility patients under 21 and over 65 years of age; and the institution that is licensed or formally approved as a hospital by the New Jersey Department of Health and Senior Services, or certified by the officially designated authority in the state in which the hospital is located; meets the requirements for participation in Medicare (Title VIII) as a hospital; and meets the criteria for participation as stated in N.J.A.C. 10:52–1.2A.

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

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

"Physician services" means those services provided within the scope of practice of a doctor of medicine (M.D.) or osteopathy (D.O.) as defined by the laws of New Jersey, or

if in practice in another state by the laws of that state, and which services are performed by or under the direction and/or personal supervision of the physician. (See also N.J.A.C. 10:54–1.2.)

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

"Rate year" means the year in which current reimbursement takes place.

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

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

Amended by R.1997 d.396, effective September 15, 1997.
See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).
Added "Entity"; and amended "Hospital" and "Outpatient hospital services".

Case Notes

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

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

10:52–1.2A Criteria for participation: outpatient hospital services

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

(b) Each site shall meet all of the following criteria prior to receiving reimbursement from the Medicaid program as an outpatient hospital service, effective in accordance with the dates in (c) below:

1. The entity shall be physically located in close proximity to the hospital, and both the entity and the hospital shall service the same patient population (such as from the same service or catchment area);

i. In determining close proximity, the following factors will be considered:

(A) The distance between the entity and the inpatient hospital facility;

(B) The physical location (inner-city, urban, suburban or rural area) of the inpatient hospital facility and the entity; and

(C) The availability of other inpatient hospital facilities providing the same services located closer to the entity than the hospital requesting the outpatient designation.

2. The entity shall be an integral and subordinate part of the hospital, and as such, shall be operated with other departments of that hospital under the common hospital licensure issued by the New Jersey Department of Health and Senior Services, in accordance with N.J.A.C. 8:43G, or under the certification provisions of the appropriate State agency, in accordance with N.J.A.C. 10:52–1.2;

3. The entity shall be included under the accreditation of the hospital as specified by N.J.A.C. 10:52–1.2 and that accrediting body shall have recognized the entity as part of the hospital;

4. The entity shall be operated under common ownership and control (such as common governance) by the hospital, as evidenced by the following:

i. The entity shall be subject to common bylaws and operating decisions of the hospital's governing body;

ii. The hospital shall have final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the entity; and

iii. The entity shall function as a department of the hospital with significant common resource usage of buildings, equipment and service personnel on a daily basis;

5. The entity director shall be under the direct day-to-day supervision of the hospital, as evidenced by the following:

i. The entity director or individual responsible for the day-to-day operations at the entity shall maintain a daily reporting relationship and be accountable to the chief executive officer of the hospital, and report through that individual to the governing body of the hospital; and

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

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

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

"Informed Consent" means the voluntary knowing assent from the individual on whom any sterilization is to be performed after he or she has been given (as evidenced by a document executed by such individual) and has been given:

1. A fair explanation of procedures to be followed;

2. A description of attendant discomforts and risks;

3. A description of benefits to be expected;

ii. Administrative functions of the entity, such as, but not limited to, records, billing, laundry, housekeeping, and purchasing shall be integrated with those of the hospital;

6. Clinical services of the entity and the hospital shall be integrated as evidenced by the following:

i. Professional staff of the entity shall have clinical privileges in the hospital;

ii. The medical director of the entity, if the entity has a medical director, shall maintain a day-to-day reporting relationship to the chief medical officer or similar official of the hospital;

iii. All medical staff committees or other professional committees at the hospital shall be responsible for all medical activities in the entity;

iv. Medical records for patients treated in the entity shall be integrated into the unified records system of the hospital;

v. Patients treated at the entity shall be considered patients of the hospital and have full access to all hospital services; and

vi. Patient services provided in the entity shall be integrated into corresponding inpatient and/or outpatient services, as appropriate, by the hospital;

7. The entity shall be held out to the public as a part of the hospital, such that patients shall know that they are entering the hospital and shall be billed accordingly; and

8. The entity and the hospital shall be financially integrated as evidenced by the following:

i. The entity and the hospital shall have an agreement for the sharing of income and expenses; and

ii. The entity shall report its costs in the cost report of the hospital using the same accounting system for the same cost reporting period as the hospital's.

(c) In order for a service provided at the site to be reimbursed as an outpatient hospital service, effective on the dates indicated in (c)2 and 3 below, the following reporting requirements shall be met for approval by the Division:

1. If the location in which the services are provided is located in or contiguous to the main inpatient hospital, the Division shall assume that these outpatient hospital services meet the criteria for participation pursuant to (b) above; therefore, the reporting requirements in (c)2 and 3 below shall not be required for these services. However, even though the services are located contiguous to the main inpatient hospital, (d) below shall apply.

2. All hospitals with existing entities as defined in this section, which do not meet the requirements in (c)1 above, shall submit a report to the Division within no later than October 15, 1997 indicating each location, the type of services provided, and how each entity meets the criteria for participation set forth in (b) above. The Division shall review each hospital's submission and determine whether or not the service provided at the entity is reimbursed appropriately as an outpatient hospital service in accordance with (b) above. A determination of and notification of the approval or denial for reimbursement as an outpatient hospital service shall be issued by the Division.

i. Pending the Division's review process, the entity shall be reimbursed at the interim rate, as specified by N.J.A.C. 10:52–4.3(a).

ii. If the entity is approved to be reimbursed for a specific outpatient hospital service, the service shall continue to be reimbursed as an outpatient hospital service in accordance with N.J.A.C. 10:52–4.3, effective on the date of approval.

iii. If the entity is denied approval for reimbursement of a specific outpatient service, the reimbursement for that service as an outpatient hospital service shall be discontinued 20 days after the date on the determination letter. However, for services provided prior to the date that reimbursement as an outpatient hospital service is discontinued, adjustments shall be made to the cost report for entities that are not considered hospital-based, in accordance with N.J.A.C. 10:52–4.3(a).

3. After September 15, 1997, all hospitals which intend to provide a new outpatient hospital service or existing service at a new location which is not contiguous to the inpatient hospital shall request and obtain approval from the Division before receiving Medicaid reimbursement as an outpatient hospital service.

i. The hospital shall report to the Division the location of each entity, the type of service provided, and how each entity meets the criteria for participation set forth in (b) above.

ii. The Division shall review each hospital's submission and determine whether or not the service provided by the entity shall be reimbursed as an outpatient hospital service. A determination of and notification of the approval or denial as an outpatient hospital service shall be issued by the Division and include the effective date of the notification of the approval or denial.

4. All information necessary, as specified in (c)3i above, for the Division to determine whether or not the services provided at the entity are approved as outpatient hospital services shall be sent to the following address:

Division of Medical Assistance and Health Services
Provider Enrollment Unit
PO Box 712, Mail Code #9
Trenton, New Jersey 08625–0712

5. In the event information is not submitted as required by (c)2 and 3 above, the service provided at the entity shall be neither approved nor reimbursed as an outpatient hospital service for services provided on or after September 15, 1997.

(d) Once the Division approves the entity to be reimbursed as an outpatient hospital service, the Division or its settlement agent, as specified in N.J.A.C. 10:52–4.7, shall ensure that the information submitted is in compliance with (b) above. A review may occur at any time at the Division's discretion, including, but not limited to, the time of the audit of the hospital's cost report. If it is determined that the service provided by the entity is not provided consistent with the criteria for participation, as specified in (b) above, the Division shall notify the hospital of its denial of the service and disallow the costs and the related reimbursement for any time that service or entity was not in compliance with these rules.

(e) Close proximity means the minimum distance between a hospital and an entity which will produce unduplicated services sufficient to meet the access and service needs of the population being served. The Division shall grant an exception to the close proximity requirement in (b)1 above on a case-by-case basis, if the exception provides access to the service by the population being served where access to the service has been limited. If an exception is granted for a specific service at an entity and that service changes, or the entity changes location, a hospital shall reapply for an exception. Requests for exceptions for entities existing prior to September 15, 1997 shall be sent to the Division in accordance with (c)2 above. A request for an exception for new entities attempting to be reimbursed as a hospital outpatient service after September 15, 1997 shall be sent to the Division in accordance with (c)3 above.

1. The following are examples of when the Division will grant an exception to the close proximity criterion stated in (b)1 above.

i. When access and/or availability to a particular service within a particular geographic area is limited; or

ii. When the availability of transportation to a particular service within a particular geographical area is limited.

(f) If the services provided at the entity are not approved by the Division as an outpatient hospital service, the entity may apply as a provider of another type of service to the Provider Enrollment Unit of the Division or the fiscal agent, as appropriate, consistent with N.J.A.C. 10:49–3 and 4, and the procedures for enrollment as indicated in the appropriate provider services manuals, such as for clinics, in N.J.A.C. 10:66, Independent Clinic Services, or in N.J.A.C. 10:54, Physician Services.

(g) If the hospital is not satisfied with the Division's determination, all appeals shall meet the requirements of the administrative hearing process in accordance with N.J.A.C. 10:49–10.3.

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

10:52–1.3 Eligibility; claim procedures

(a) A hospital shall adhere to the following procedure for completing the form, the "Public Assistance Inquiry (PA–1C)" to inform the appropriate agency that an individual intends to file a Medicaid application:

1. For those aged, blind or disabled persons with limited income and resources who appear to be eligible for Supplemental Security Income (SSI)/Medicaid, a hospital shall complete the form PA–1C and send it to the Social Security Administration (SSA) District Office serving their locale to initiate the eligibility process. The date of the inquiry shall protect the application date provided that the individual follows through with filing of an application.

2. For the aged, blind and/or disabled individuals, and/or pregnant women and/or certain children who do not qualify for or who do not want an SSI money payment from the Social Security Administration and/or do want to be a Medicaid recipient through "Medicaid Only" or New Jersey Care ... Special Medicaid Programs, a hospital shall complete the form PA–1C and send it to the appropriate county welfare agency (CWA).

3. A hospital shall submit the form PA–1C to the County Welfare Agency (CWA) immediately after the birth of a newborn of a mother who is or may become eligible for Medicaid. (Information on the newborn shall be included in item 1, 2, 4, 11a and 15 only. The mother's signature shall be included in Item 23.)

i. There shall be no requirement for joint hospitalization of a mother and newborn as the sole condition for which claims for services to the newborn may be submitted using the mother's Person Number.

ii. A mother who is a Medicaid recipient and her newborn shall have the same HSP (Medicaid) Case Number when they are a part of the same household, but each shall be assigned his or her own Person Number.

iii. A hospital shall be permitted to submit a claim for services to a newborn for 60 days from the date of the birth through the end of the month in which the 60th day occurs or until the newborn is assigned his or her own Person Number, whichever happens first.

iv. After the extended time frame of 60 days from the date of birth through the end of the month in which the 60th day occurs or upon the assignment of the newborn's Person Number, the newborn's personal data shall be used on the claim form as soon as it is available to the hospital. The mother's personal data shall not be used on the claim form after this time frame or after the newborn's Person Number is available to the hospital.

4. Previously submitted PA–1C forms shall be updated by the hospital if subsequent facts emerge that alter the original referral.

i. When it is determined that the original referral to the Social Security Administration was incorrect, the hospital shall forward a copy of the original PA–1C to the CWA with a note of explanation (see also N.J.A.C. 10:49–2 in Administration for further information on Medicaid eligibility).

10:52–1.4 Eligibility of recipient for hospital services

(a) Hospital services shall not be reimbursed by Medicaid when hospital services were rendered prior to and after period of recipient eligibility, as determined in accordance with N.J.A.C. 10:49–2.5; except that, when a Medicaid recipient in an acute care general hospital loses eligibility during an inpatient hospital stay, but was eligible on the date of admission, eligibility shall continue for hospital inpatient services for the entire length of that hospital stay.

(b) When a patient is admitted to a hospital and is determined Medicaid eligible subsequent to the date of admission, charges incurred during the ineligible period of the hospital stay shall not be reimbursable, unless coverage is pursued and approved under retroactive eligibility.

(c) For coverage of services rendered prior to date of application for Medicaid, the recipient shall apply for retroactive eligibility, in accordance with N.J.A.C. 10:49–1.1.

10:52–1.5 Covered Services (Inpatient and Outpatient)

(a) Inpatient services which shall be covered by the Division are those services ordinarily furnished by an approved hospital maintained for the treatment and care of patients and provided to any Medicaid recipient for whom professionally developed criteria and standards of care were used to determine that the recipient warranted an appropriate hospital level of care for a given diagnosis and/or problem.

1. Inpatient psychiatric services in approved beds in a general hospital for patients of any age shall be covered services.

2. Inpatient room and board service shall be provided in a semi-private accommodation. Accommodations other than semi-private require certification of medical necessity or lack of availability of semi-private accommodations.

3. Inpatient services in an acute general hospital rendered the day after acute care is no longer medically necessary shall be covered only under specified conditions. (See Social Necessity Days in N.J.A.C. 10:52–1.11 and Administrative Days in N.J.A.C. 10:52–1.6.)

4. Non-physician services, supplies and equipment supplied by an outside vendor to Medicaid recipients who are receiving inpatient acute care hospital services shall be covered directly under the hospital reimbursement system. Vendor claims for these services are the responsibility of the acute care hospital where the recipient is a patient and shall not be billed directly to the Medicaid fiscal agent.

5. For recipients in the Medically Needy Program, inpatient hospital services shall be available only to pregnant women. For information on how to identify a Medicaid recipient in the Medically Needy Program, refer to N.J.A.C. 10:49–2.3(b)4, Administration.

(b) The Division shall pay for eligible ancillary services provided during a non-covered period in an acute care hospital in the following situations:

1. When the Utilization Review Organization (URO) denies the entire admission for acute level of care; and,

2. When the URO certifies the admission as acute but "carves out" days from the approved continued stay. For eligible ancillary services that were provided during days that were "carved out" or "non-covered" and occurring in an inlier stay, no additional reimbursement by Medicaid shall be made, since the services are already included in the DRG reimbursement rate; and

3. When the URO certifies that only part of the stay is acute.

(c) Medically necessary inpatient psychiatric services provided in an approved private psychiatric hospital shall be covered by the Division for any Medicaid recipient age 65 or older; or for any other Medicaid recipient before attaining the age of 21, except that a recipient receiving the services immediately before attaining age 21 may continue to receive the services until they are no longer needed or until the recipient reaches age 22, whichever occurs first.

(d) Outpatient services that shall be covered by the Division are those medically necessary items or services (preventive, diagnostic, therapeutic, rehabilitative, or palliative) provided to an outpatient, by or under the direction of a physician or dentist, except for the supervision of the certified nurse midwife services, pursuant to the rules of the Division and applicable Federal regulations, including those services listed below:

1. Outpatient psychiatric services in general hospitals and private psychiatric hospitals for patients of all ages;

2. Same Day Surgery shall be covered by the Division when the Medicaid recipient:

i. Is identified on the UB–92 claim form as a 131 or 136 bill type in accordance with N.J.A.C. 8:31B–2.1; and,

ii. Is discharged before midnight of the day of admission so the admission date and discharge date are the same; and,

iii. Had surgery performed in a fully equipped operating room, for example, one routinely equipped and

capable of providing general anesthesia, and identified by an operating room charge on the claim; and,

iv. Had a normal discharge, for example was not transferred, did not leave "against medical advice", and was not discharged dead. (See N.J.A.C. 8:31B–3.11 and 8:31G–32—Same day surgery.)

3. Physician services in hospitals (outpatient) (that is, specifically unbundled physicians): A physician practicing in a hospital outpatient department whose reimbursement is not part of the hospital's cost may bill fee-for service if the arrangement with the hospital permits it.

4. Family planning services including medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

5. The Norplant System (NPS) shall be a Medicaid covered service when provided as follows:

i. The NPS is used only in reproductive age women with established regular menstrual cycles;

ii. The Food and Drug Administration (FDA)-approved physician prescribing information is followed; and

iii. Patient education and counseling are provided relating to the NPS, including pre and post insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

iv. The visit relating only to the insertion and removal of the Norplant System (NPS) is not reimbursable on the day of insertion or removal.

v. Only two insertions and two removals of the NPS per recipients are permitted during a five year continuous period.

vi. The hospital shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intra-uterine device.

(e) Transfer from one outpatient facility to another outpatient facility, or a change from an outpatient facility to a private practitioner's care is allowable; however, effort shall be made to avoid duplication of diagnostic tests or services.

(f) For policies and procedures for Ambulatory Surgical Centers, see N.J.A.C. 10:52–2.1 and N.J.A.C. 10:66–5, Independent Clinic Services.

(g) For policies and procedures for hospital-affiliated home health agencies, see N.J.A.C. 10:52–2.5 and N.J.A.C. 10:60, Home Care Services.

(h) For policies and procedures for Medical Day Care Centers (Hospital Affiliated), see N.J.A.C. 10:52–2.6 and N.J.A.C. 10:65, Medical Day Care Services.

(i) For policies and procedures for HealthStart (Comprehensive Maternity and Pediatric Care Services), see N.J.A.C. 10:52–3. For policies and procedures for Early and Periodic Screening Diagnostic and Treatment, see N.J.A.C. 10:52–2.5.

(j) For other policies and procedures related to specific services, both inpatient and outpatient, see N.J.A.C. 10:52–2.

10:52–1.6 Disproportionate share of adjustments

The Department of Human Services/Division of Medical Assistance and Health Services shall, upon receipt of documentation from the Department of Health and Senior Services apply an offset to a hospital's disproportionate share hospital and/or Medicaid or NJ KidCare beneficiary care payments to collect delinquent statutory and/or regulatory debts arising under the Health Care Facilities Planning Act, N.J.S.A. 26:2H–1 et seq., and the implementing regulations, owed by the hospital to the State.

New Rule, 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. 10:52–1.6, Non-Covered Services (Inpatient and Outpatient), recodified to N.J.A.C. 10:52–1.7.

10:52–1.7 Non-Covered Services (Inpatient and Outpatient)

(a) Non-covered services (inpatient and outpatient) that shall not be eligible for payment by the Division are as follows:

1. Hospital admissions of the following description:

i. Admission for any condition for which hospitalization is not medically necessary;

ii. Admission primarily for rest cure, custodial care, convalescent care, or diet therapy for exogenous obesity;

iii. Admission for illnesses which, according to generally accepted professional standards, are not amenable to favorable modification. However, psychiatric services in a general hospital shall be covered for the purpose of determining that such disorders or illness (such as senility) are not amenable to favorable modification;

iv. Admission for diagnostic procedures which may be done on out-of-hospital basis, including but not limited to laboratory tests, electrocardiograms, and diagnostic radiological services;

v. Admission or extension of hospital stay solely for research or teaching studies;

vi. Admission for inpatient services provided in an approved private psychiatric hospital unless:

(1) The Medicaid recipient is age 65 or over; or,

(2) The Medicaid recipient has not attained age 21, except that an individual receiving such services immediately preceding the date on which he or she attained age 21 will continue to be covered until the date the individual no longer requires such services or the date the individual reaches age 22, whichever occurs first; and,

vii. Admission of recipients in the Medically Needy Program, except for pregnant women. For information on how to identify a Medically Needy recipient, see N.J.A.C. 10:49–2.3(b), Administration.

2. Any service or item requiring prior authorization (see N.J.A.C. 10:52–1.9, Prior authorization) which has been performed without prior authorization.

3. Medically unnecessary items and services, as follows:

i. Any service or item which is not medically necessary for the prevention, diagnosis, palliation, rehabilitation, or treatment of a disease, injury or condition;

ii. Inpatient hospital services rendered prior to the day it is medically necessary for the diagnostic services and/or surgical or medical treatment for which the patient is admitted.

iii. Inpatient hospital services rendered after the day it is medically necessary in a general hospital, except when special circumstances, that is, "social necessity", to prevent the discharge or transfer of the patient or when an inpatient is eligible for "administrative days" (see N.J.A.C. 10:52–1.13, Social Necessity and N.J.A.C. 10:52–1.8, Administrative Days).

iv. Inpatient hospital services denied for lack of medical necessity shall not be covered.

4. Private duty nursing services in the hospital inpatient setting;

5. Research or Teaching Studies;

6. Surgery (Elective), as follows:

i. Cosmetic Surgery, except that the Division shall consider authorization of a request from the patient's physician for elective cosmetic surgery, if a significant redeeming medical necessity can be demonstrated; and,

ii. Second Opinion Elective Procedures without meeting the Second Opinion requirement (see N.J.A.C. 10:52–1.12—Second Opinion Program);

7. Transportation, except as in N.J.A.C. 10:52–2.15—Transportation Services (Hospital-based);

8. Fee-for-service billed by a hospital-based physician who is salaried and whose services are reimbursed as part of the hospital's cost;

9. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory, radiological and diagnostic services and surgical procedures:

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose then the hospital shall submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, Mail Code # 14, Trenton, New Jersey 08625–0712;

10. Other services and items not directly related to the care of the patient, such as:

i. Inpatient items and services including guest meals and accommodations, television, telephone, and similar items and services. Personal items shall be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items; and,

ii. Outpatient items and services which are not usually part of the outpatient service; for example, eyeglasses, custom-made limbs and braces, or surgical supplies.

11. Services and items that are billed by, and payable to, another vendor;

12. Services and items furnished by the hospital, for which the hospital does not normally charge;

13. Services and items not medically required for the diagnosis or treatment of a disease, injury or condition; and,

14. Services provided to a patient during the same period for the same condition by both private practitioner and outpatient facility, or by two different facilities, shall not be covered. Payment shall be made for only one service, except in an emergency. (For definition of an emergency, see N.J.A.C. 10:49–6.1, Administration.)

Recodified from N.J.A.C. 10:52–1.6 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. 10:52–1.7, Administrative Days (Nursing Facility Level of Care)—General, Special (Classification A & B) and Private Psychiatric Hospitals, recodified to N.J.A.C. 10:52–1.8.

Case Notes

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

10:52–1.8 Administrative Days (Nursing Facility Level of Care)—General, Special (Classification A & B) and Private Psychiatric Hospitals

(a) For a patient who is no longer in need of inpatient acute level of care and who is awaiting placement in a nursing facility, payment shall be made for "administrative

days" if the general, special, rehabilitation, or the private psychiatric hospital demonstrates that:

1. All other possible health insurance benefits have been utilized;

2. Discharge planning was initiated upon admission of the patient to the hospital, reviewed, and updated regularly. Within one working day of identifying a Medicaid recipient as being at risk for nursing facility placement, the hospital notified the Medicaid District Office and the county welfare agency (CWA). See N.J.A.C. 10:52–1.10 in this chapter—Pre-Admission Screening for Nursing Facility Placement;

3. The care and services provided are medically necessary, that is, the attending physician wrote a discharge order from acute care or made a written entry in the medical record that the patient could be transferred to a nursing facility (NF); and a Pre-Admission Screening Evaluation (PAS) confirmed the necessity for nursing facility services; and

4. Placement could not be made in a NF, as substantiated by documentation of timely and continuous contact (at a minimum, twice a week) with family members, nursing facilities (NFs), and placement agencies.

(b) Upon satisfaction of all the conditions listed under (a)1 through 4 above, payment will be made at the statewide weighted average per diem rate paid to Medicaid participating NFs, as determined on January 1 of each year;

(c) N.J.S.A. 30:4D–6.7 and 6.8 requires every nursing facility in the State to reserve a Medicaid recipient's bed up to 10 days when the recipient is transferred from the nursing facility to a general or private psychiatric hospital. If the discharged Medicaid recipient is unable to return to the nursing facility before the end of the 10 day period, the discharged recipient shall have priority for the next available Medicaid bed in the facility. When the recipient is admitted to the hospital under the bed reserve policy, the hospital shall:

1. Involve the NF in the preparation of the hospital's discharge planning; and,

2. Advise the NF of an anticipated discharge date; and,

3. Keep the NF informed of the patient's progress, particularly if something unexpected happens which causes a revision to the discharge plan; and,

4. Give the NF as much advanced notice as possible to prepare for the return of the patient; and,

5. When the 10 day bed reserve is exceeded and no bed is available in the NF from which the recipient was transferred, the hospital must provide the level of NF care determined by the Medicaid Regional Staff Nurse during the Pre-Admission Screening Evaluation until such time as a bed is available to the Medicaid recipient. (See N.J.A.C. 10:52–1.10.)

(d) For the information of hospital staff assisting in the discharge of a patient to a NF, N.J.S.A. 30:4D–17.3, prohibits, in general, a NF from requiring private pay contracts or donations under certain conditions on behalf of Medicaid recipients. To enforce this prohibition, the law establishes both criminal and civil penalties. (See also N.J.A.C. 10:49–9.7, Administration.)

(e) N.J.S.A. 10:5–12.2 of the New Jersey Civil Rights Act prohibits a NF from discriminating against Medicaid eligible persons and recipients of municipal general assistance by denying them admission when the NF's Medicaid occupancy level is below the Statewide occupancy level.

(f) Provisions for reimbursement of administrative days (nursing facility level of care) do not apply to special hospitals (Classifications A and B).

Recodified from N.J.A.C. 10:52–1.7 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. 10:52–1.8, Prior Authorization, recodified to N.J.A.C. 10:52–1.9.

10:52–1.9 Prior authorization

(a) Prior authorization shall be required for certain dental procedures (see N.J.A.C. 10:56, Dental Services) and partial hospitalization provided in the outpatient department of an acute care hospital beyond exempt time frames (see N.J.A.C. 10:52–2.9(c).)

(b) Other services require adherence to special procedures, such as the requirements of the Second Opinion Program, before certain elective surgical procedures are performed. Specific services are described in the "Policies and Procedures for Providing Specific Services", in N.J.A.C. 10:52–2. Hospital entitlement to Medicaid payment is subject to providing these services in accordance with the policies and procedures as outlined. For general information about prior and retroactive authorization, see N.J.A.C. 10:49–6.1, Administration.

(c) For out-of-State services, see 42 CFR 431.52. Prior authorization as outlined in (d) below shall be required for inpatient and outpatient hospital services provided to a recipient outside the State of New Jersey, except as provided in (e) below. Hospital covered services for a recipient with an HSP (Medicaid) Case Number with the 1st and 2nd digits of 90 or the 3rd and 4th digits of 60, residing out-of-State at the discretion of the New Jersey Department of Human Services, shall not require prior authorization. However, any covered service that requires prior authorization as a prerequisite for payment to New Jersey Medicaid providers also requires prior authorization if it is to be reimbursed by the Division in any other State, except that prior authorization is not required for emergency and interstate transfers.

(d) A request for authorization for reimbursement for out-of-State services shall be directed to the Medicaid District Office (MDO) in the area where the recipient resides except as listed in (d)1 below. For a listing of MDOs, see the Directory at the end of the N.J.A.C. 10:49, Administration.

1. Exception: Prior authorization of out-of-State psychiatric services shall be directed to the psychiatric consultant in the Office of Medical Affairs and Provider Relations of the Division of Medical Assistance and Health Services, in accordance with N.J.A.C. 10:54, Physician Services.

2. For a recipient who resides in New Jersey in other than a hospital and who is to be admitted or referred to an out-of-State hospital for elective inpatient or outpatient services, the physician planning such action shall sign a statement that the medically necessary service is not available at a reasonable distance within the State of New Jersey; and

3. For a recipient who is traveling outside New Jersey and who is to be admitted to an out-of-State hospital for elective surgery, the attending physician shall justify by a signed statement that an attempt to return to a New Jersey hospital would create a significant risk to life or health or would create the need for an unreasonable amount of travel for the recipient.

4. The Division shall notify, in writing, the physician making the request.

i. If authorized, the authorization letter of the Medical Consultant of the Division shall be forwarded to the requesting physician. When arranging for hospital admission, the physician shall forward a copy of the authorization letter to the hospital. When submitting the claim for services to the fiscal agent, the hospital shall attach the authorization letter, or a copy of the letter, to the claim.

(e) Prior authorization shall not be required for emergencies nor for interstate hospital transfers. However, in these instances, the hospital shall attach the attending physician's signed statement to the claim, attesting to the nature of the emergency or, for a hospital interstate transfer, attesting to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey.

(f) For Medicaid recipients who have the diagnosis of Head Injury, for whom it is medically necessary to discharge from a hospital or special hospital to a special program in a NF, or to home care through the Traumatic Brain Injury Waiver Program, the hospital discharge planner and/or social worker shall obtain prior authorization for the placement (for either in-State or out-of-State patients) from the Medicaid District Office in the county where the recipient is residing. For information on the Traumatic Brain Injury Waiver program, see N.J.A.C. 10:60–5.2 and 5.3 and N.J.A.C. 10:49–17.5, Administration.

Recodified from N.J.A.C. 10:52–1.8 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. 10:52–1.9, Pre-Admission screening for nursing facility (NF) placement, recodified to N.J.A.C. 10:52–1.10.

10:52–1.10 Pre-Admission screening for nursing facility (NF) placement

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

"Pre-Admission Screening" (PAS) means that process by which all Medicaid eligible recipients seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF, receive a comprehensive needs assessment by the Regional Staff Nurse to determine their long term care needs and the most appropriate setting for those needs to be met, pursuant to N.J.S.A. 30:4D–17.10. (P.L. 1988, c.97.)

"Pre-Admission Screening and annual resident review (PASARR)" means that process by which all individuals with mental illness (MI) or mental retardation (MR), regardless of payment source, are screened prior to admission to a NF and annually thereafter in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition.

"PASARR Level I" means the process of identification of individuals diagnosed with a serious mental illness (MI) or mental retardation (MR).

"PASARR Level II" is the process of evaluating and determining whether NF services and specialized services are needed.

"Specialized Services for Mental Illness (MI)" means those services offered when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based on a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24–hour supervision for the individual, specific therapies and activities are prescribed, with the following objectives: a) to diagnose and reduce behavioral symptoms; b) to improve independent functioning; and c) as early as possible, to permit functioning at a level where less than Specialized Services are appropriate. Specialized Services go beyond the range of services which a NF is required to provide.

"Specialized Services for Mental Retardation (MR)" means those services required when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24–hours per day, to teach the individual functional

skills. Specialized Services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is required to provide.

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared by the Medicaid Regional Staff Nurse (RSN) during the Pre-Admission Screening (PAS) assessment process. The HSDP reflects the individual's current or potential problems, required care needs, and the Track of Care, and shall be forwarded to the authorized care setting.

"Nursing Facility (NF)" means an institution (or distinct part of an institution) certified for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24–hour basis to Medicaid recipients (children and adults) who, due to medical disorders, developmental disabilities, and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for the care and treatment of mental diseases which require continuous 24–hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

"Regional Staff Nurse (RSN)" means a registered professional nurse employed by the Division who performs health needs assessments as required by this section.

"Track of Care" means designation of the setting and scope of Medicaid services as determined by the PAS process conducted by the RSN following assessment of the Medicaid recipient or potential Medicaid recipient, as follows:

1. "Track I" means long-term NF care;

2. "Track II" means short-term NF care; and,

3. "Track III" means long-term care services in a community setting.

(b) Pre-Admission Screening (PAS) authorization shall be required prior to admission to a Medicaid certified NF of a Medicaid recipient, or an individual who may become a Medicaid recipient within six months following placement in a Medicaid certified NF. The Medicaid Regional Staff Nurse (RSN) will assess each individual's care needs and determine the appropriate setting for the delivery of needed services. The RSN will authorize or deny NF placement based on service requirements at N.J.A.C. 10:63–2 and the feasibility of alternative placement and will designate the track of care, in accordance with N.J.A.C. 10:63–1.11.

(c) PAS authorization is also required for individuals identified as having MI or MR regardless of the payment source. The PASARR assessment and authorization process shall be subsumed within the State's PAS protocols, as required by (d) below.

1. PASARR Level I Identification Screens shall be required for individuals diagnosed as MI, MR, or related conditions.

2. An individual is considered to have mental illness (MI) if he or she has a serious mental illness, such as schizophrenia, mood disorder, paranoia, panic or severe anxiety disorder, or similar condition, diagnosable in the Diagnostic and Statistical Manual of Mental Disorders (DSMIII-R; 1987 edition) (available from the American Psychiatric Association, 1400 K St. NW, Washington, DC 20005), which leads to a chronic disability and which meets the PASARR requirements for diagnosis, level of impairment, and duration of illness.

i. An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSMIII-R; 1987 edition) and does not have a serious mental illness.

3. An individual is considered to have mental retardation if he or she has a level of retardation (mild, moderate, severe or profound) described in the "American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983)" or a related condition, as defined by, and pursuant to, Section 1905(d) of the Social Security Act (Omnibus Budget Reconciliation Act of 1987—P.L. 100–203); 42 U.S.C. 1396(d), and i below. An individual with a diagnosis of MR or a related condition and a diagnosis of dementia must have the PASARR Level II Specialized Service Screen, prior to admission to a Medicaid certified nursing facility.

i. "Persons with related conditions" means individuals who have severe, chronic disability that meet all of the following conditions:

(1) Persons who have diagnosis of mental retardation (MR) or other developmental disability, such as cerebral palsy, epilepsy, autism, spina bifida, or other neurological impairment;

(2) Persons who have a history or past records that show that the onset of the mental retardation or related conditions occurred prior to age 22; and

(3) The disability is severe and chronic in nature.

4. PASARR Level II Specialized Services Screens shall be conducted for mentally ill or mentally retarded individuals only if the Medicaid RSN's assessment results in authorization of NF placement.

i. Level II Specialized Services Screens require that a psychiatric examination be performed by a Board eligible/certified psychiatrist to determine the need for specialized services, in accordance with (e) below.

ii. Level II Specialized Services Screens for MR individuals will be performed by the Division of Developmental Disabilities (DDD) to determine the need for specialized services, in accordance with (d) below.

5. After an initial PASARR assessment has been completed, the individual transferred from a nursing facility to an acute care general hospital or to a psychiatric hospital with an admitting diagnosis of MI, shall not require a Level II Specialized Services Screen or a PAS nursing facility assessment prior to readmission to a nursing facility. If the individual is transferred to a different facility, the hospital discharge planner shall advise the admitting NF of the individual's former NF placement.

6. For individuals diagnosed with Alzheimer's or related dementias, documentation to support the diagnosis, including the history, physical examination and diagnostic workup shall be provided to the admitting Medicaid certified nursing facility for the individual's clinical record.

7. Hospitals shall not transfer individuals to Medicaid certified NFs until Level II Specialized Service Screens have been conducted and the hospital has received MDO notification that specialized services are not required.

(d) The determination of the necessity for NF services shall be performed through Pre-Admission Screening (PAS), as mandated by N.J.S.A. 30:4D–17.10. The Medicaid Regional Staff Nurse (RSN) shall determine the necessity for nursing facility services for Medicaid recipients, for individuals who may become Medicaid recipients within six months following admission to a Medicaid certified facility, and for individuals identified as meeting PASARR Level I criteria. The MDO having jurisdiction for the area where an acute care hospital is located has the responsibility for completing the PAS assessment, regardless of the recipient's county of residence or anticipated county of discharge.

1. The Medicaid RSN shall:

i. Review the medical, nursing, and social information obtained at the time of assessment, as well as any other supporting data;

ii. Assess the individual's care needs;

iii. Determine the appropriate setting for the delivery of needed services;

iv. Authorize or deny NF placement based on service requirements at N.J.A.C. 10:63–2 and the feasibility of alternative care;

v. Designate the track of care; and

vi. Advise the discharger planner and/or social worker of the appropriate setting for the delivery of needed services and, if appropriate, for the need for the PASARR Level II Specialized Services Screen.

2. The Medicaid RSN shall schedule and perform the assessment process within three working days of the hospital discharge planner and/or social worker's initial contact with the MDO. Individuals who exhibit unstable, severe medical conditions, such as a patient in the Intensive Care or Coronary Care Unit, shall not be referred for PAS until that condition has stabilized.

3. A signed "Release of Information form (MCNH–69 Rev. 11/89)" shall be obtained from the patient. If the patient refuses NF placement, home care services, or participation in the PAS assessment process, the Medicaid RSN shall make every effort to obtain a signed participation declination statement, which shall be included in the patient's MDO case record.

4. NF placement approval: The Medicaid RSN shall verbally advise the hospital discharge planner and/or social worker and patient and/or family of the assessment decision.

i. For a Track I or II determination, the Medicaid RSN shall leave a copy of the HSDP and signed approval letter with the discharge planner/social worker. For individuals requiring Level II Specialized Service Screens, the signed approval letter shall be forwarded only after the determination has been made that no specialized services are required.

ii. For a Track III determination, the Medicaid RSN shall leave a copy of the HSDP and signed approval letter with the discharge planner and/or social worker to forward to the home care provider. The discharge planner and/or social worker shall arrange needed home health services and forward a copy of the HSDP and signed approval letter to the home care agency. A Track III determination shall not be an authorization for NF services.

iii. The original approval letter signed by the Medicaid RSN shall be sent by the MDO to the patient and/or family with copies to the county welfare agency (CWA).

iv. A copy of the HSDP that was left with the hospital discharge planner and/or social worker by the Medicaid RSN, shall be attached to the hospital discharge material and forwarded with the patient to the admitting NF.

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

5. NF placement denial: The Medicaid RSN shall verbally advise the hospital discharge planner and/or social worker and patient and/or family of the assessment decision. The Medicaid RSN shall leave a signed copy of the NF placement denial letter with the discharge planner/social worker. The original denial letter, signed by

the Medicaid RSN, shall be sent to the patient and/or family by the MDO, with copies to the CWA.

(e) The hospital discharge planner and/or social work staff shall be responsible for identifying a Medicaid recipient inpatient or a Medicaid applicant inpatient who may be at risk of NF placement.

1. The identification process shall also include any inpatient in need of NF care who may become a Medicaid recipient within six months after NF admission and individuals meeting PASARR Level I criteria. (See N.J.A.C. 10:52–1.8(c).) These patients shall be referred by the hospital to the MDO and the CWA or the basis of the "At-Risk Criteria for Nursing Facility Placement and Referral to the Medicaid Office for PAS Evaluation" in (f) below. Medicaid recipients already residing in Medicaid participating facilities who are transferred to an acute care hospital and who are returning to either the same or a different NF, shall not require PAS authorization.

i. Within one working day of identifying an inpatient as being at risk for NF placement, the Hospital Discharge Planner and/or Social Worker shall:

(1) Make a telephone or FAX referral to the MDO and the CWA; and,

(2) If not already a Medicaid recipient, generate a Public Assistance Inquiry (PA–1C) to initiate the application process for Medicaid.

(3) Within two working days of the telephone referral to the MDO and CWA, the Hospital Discharge Planning Office shall forward the completed "Hospital Pre-Admission Screening Referral (PAS–5, 2/90)" to the MDO, unless it was "faxed" on the day of the referral.

2. The PASARR Level II Specialized Service Screens shall be performed by a Board eligible or Board certified psychiatrist for final determination, as follows:

i. The hospital discharge planning unit and/or social services department shall immediately arrange through the individual's attending physician, a consultation by a Board eligible or Board certified psychiatrist to complete the "Psychiatric Evaluation (DMH & H, 1994) form. (The "Psychiatric Evaluation" form shall not be completed until such time as the Medicaid RSN has approved Medicaid-certified NF placement.)

ii. Within 48 hours of the psychiatrist's review of the recipient or potential Medicaid recipient, the completed "Psychiatric Evaluation" form shall be sent to the Division of Mental Health and Hospitals, PO Box 727, Trenton, New Jersey 08625–0727, Attention: PASARR Coordinator.

(1) A supply of the "Psychiatric Evaluation" form may be ordered from the PASARR Coordinator in the Division of Mental Health and Hospitals.

iii. The MDO shall contact the appropriate Regional Office of the Division of Developmental Disabilities (DDD) agency to advise them of the need for a MR Level II Specialized Service Screen. The MR Level II Specialized Service Screen will be completed by the DDD staff within three working days of the MDO contact.

iv. The final determination of the specialized services review by the DMH & H and/or DDD agencies shall be communicated to the Medicaid District Office who, in turn, shall provide the hospital discharge planning unit and/or social services department with the approval or denial decision for placement in a Medicaid NF.

(f) The "At-Risk Criteria for Nursing Facility Placement and Referral to the Medicaid Office for PAS" shall be utilized by the hospital in determining if a referral for long term care services, either in an NF or in the community, is indicated, as follows:

i. The medical criteria are as follows. Has the patient experienced any of the following:

(1) Catastrophic illness requiring major changes in lifestyle and/or living conditions, that is, multiple sclerosis, stroke, multiple trauma, AIDS, amputation, neurological disease, cancer, birth defect(s), and end stage renal disease.

(2) Debilitation and/or chronic illness causing progressive deterioration of self-care skills, that is, severe chronic disease, spina bifida, progressive pulmonary disease or diabetes.

(3) Multiple hospital admissions within the past six months. (Do not refer patients admitted directly from NFs.)

(4) Previous NFs admissions within the past two years.

(5) Major health needs, that is, tube feedings, special equipment or treatments, rehabilitation/restorative services.

ii. The social criteria are as follows: In addition to the medical criteria, does the patient meet any of the following social situations:

(1) Homeless;

(2) Lives alone and/or has no immediate support system;

(3) Primary caregiver is not able to provide required care services; or

(4) Lack of adequate support systems.

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

(1) Currently eligible for Medicaid;

(2) Monthly income at/or below the current institutional specified at N.J.A.C. 10:71–5.6.

(A) 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;

(B) Has no spouse in the community and resources at/or below $26,000. (This is an indication that the patient may become Medicaid eligible within the next six months by spending down assets in an NF as private pay); or

(C) Has a spouse in the community with combined countable resources at or below $52,000. (This allows for calculation of the community spouse's resources under Medicare Catastrophic Coverage Act of 1988.)

(3) 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:

(A) 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;

(B) Has no spouse in the community and resources at/or below $28,000. (This is an indication that the patient may become Medicaid eligible within the next six months by spending down assets in a NF as private pay; or

(C) Has a spouse in the community with combined countable resources and/or below $56,000. (This allows for calculation of community spouse's resources under the Medicare Catastrophic Coverage Act of 1988.)

(g) The hospital discharge planner and/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 MDO a "Hospital Pre-Admission Screening Discharge form (PAS–6, 2/90)".

i. For any patient discharged to a NF, a Discharge Package (HSDP, discharge paper work, MDO approval letter, hospital transfer sheet, and PASARR documentation including the 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 participating NF.

ii. For those recipients discharged to community locations, the hospital social worker and/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.

10:52–1.11 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.

10:52–1.12 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 payment. 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 KidCare 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. 10:52–2.13);

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 KidCare 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 KidCare eligibility shall be verified by checking the individual's current New Jersey Validation Form before rendering any service. (See N.J.A.C. 10:49–2.3, Administration—How to Identify a Medicaid or NJ KidCare 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.

10:52–1.13 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 recipient 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 Welfare Agency (CWA), 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 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.

10:52–1.14 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. EXCEPTION: For inpatient psychiatric hospital services for individuals under the age of 21, refer to N.J.A.C. 10:52–1.15.

(b) For the 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 recipients.

"Utilization Review Organization (URO)" means an organization designated and certified by the New Jersey State Department of Health, that has review authority over hospitals for specific functions for utilization review and quality assurance for all admissions to and continued lengths of stay at general hospitals in New Jersey. The review may be delegated or non-delegated and billed to the hospital under N.J.A.C. 8:31B–3.81.

(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, Subchapters B, C, and D). Included under utilization control are: Certification and recertification of the need for inpatient care; medical, psychiatric and social evaluations; a PoC established and periodically reviewed and evaluated by a physician; and a continuous program of utilization review under which the admission of each recipient is reviewed or screened. Hospital entitlement to Medicaid payment for services rendered to a Medicaid recipient for each period of hospitalization is subject to the following requirements:

1. A physician shall certify, for each recipient 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 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 patient shall be maintained in the recipient'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 recipient 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 recipient 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 recipient is receiving.

v. The recertification for any Medicaid recipient shall be maintained in the recipient'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 recipient 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 recipient'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 recipient 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 recipient'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 while in the private psychiatric hospital.

(e) Plan of Care (PoC): Before the admission of an applicant/recipient 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 and the attending or staff physician in a private psychiatric hospital involved in the care of the individual shall establish a written PoC for each Medicaid recipient or applicant.

1. The PoC 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/or special hospitals, a physician and other personnel involved in the Medicaid recipient's case shall review each PoC at least every 60 days.

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

6. Reports of evaluations and PoCs: A written report of each evaluation and plan of care shall be entered in the applicant's or recipient'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 456.10 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 recipient or potential Medicaid recipient who is considered for admission to a NF shall receive a pre-admission screening in accordance with N.J.A.C. 10:52–1.10.

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.

10:52–1.15 Utilization control: inpatient psychiatric services for recipients 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 recipients 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 recipient'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, requirements 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. 10:52–1.14 for requirements on utilization control in an acute care general hospital.

(b) This rule applies only to inpatient psychiatric services in approved private psychiatric hospitals for the treatment of children and youths, before the recipient reaches age 21, or, if the recipient was receiving the services immediately before he reached age 21, before the earlier of the following:

1. The date the recipient no longer requires the services; or,

2. The date the recipient 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 PoC, as described in (f) below, that is:

i. Developed and implemented no later than 14 days after admission; and,

ii. Designed to achieve the recipient'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 recipients in the facility or program, and include, as 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 (PoC)" means a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary.

(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. The team shall certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipients;

2. Proper treatment of the recipient's psychiatric condition, requires services on an inpatient basis under the direction of a physician are needed; and,

3. Services can reasonably be expected to improve the recipient'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 under (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 a recipient: For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team, as described under (c) above.

2. Certification for inpatient applying for Medicaid: For an individual who applies for Medicaid while in the facility or program, the certification must be made by an interdisciplinary team responsible for the plan of care, as described under (c) above.

3. Certification—Emergency Admission: For emergency admission of a recipient, the certification must be made by the interdisciplinary team responsible for the plan of care, in accordance with Federal regulation, 42 CFR 441.156, and as described under (f)1 below.

(f) The individual PoC is as follows. 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 PoC for each applicant or recipient to improve the recipient'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 (PoC) shall:

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

ii. Be developed by a team of professionals as described in (g) below in consultation with the recipient, the recipient'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 objectives; and,

v. Include, at an appropriate time, post discharge plans and coordination of inpatient services with partial discharge plan and related community services to ensure continuity of care with the recipient'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 recipient's overall adjustments as an inpatient.

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

1. The individual PoC as described under 42 CFR 441.156, 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 recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

ii. Assessing the potential resources of the recipient's family;

iii. Setting treatment objectives; and,

iv. Prescribing therapeutic modalities to achieve the plan's objectives.

Recodified from N.J.A.C. 10:52–1.14 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. 10:52–1.15, Utilization control; outpatient psychiatric services, recodified to N.J.A.C. 10:52–1.16.

10:52–1.16 Utilization control; outpatient psychiatric services

(a) The following policies and procedures in this rule were developed to help ensure the appropriate utilization of outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a PoC, performance of periodic reviews for evaluation purposes, and supportive documentation for services rendered. Outpatient psychiatric services include the initial evaluation; individual psychotherapy; group psychotherapy; family therapy; family conference; partial hospitalization (see N.J.A.C. 10:52–2.9); psychological testing; and medication management.

(b) The policy for intake evaluation shall be as follows:

1. An intake evaluation shall be performed within 14 days or by the third outpatient visit, whichever is later, for each Medicaid recipient being considered for continued treatment, and shall consist of a written assessment that:

i. Evaluates the recipient's mental condition; and,

ii. Determines whether treatment in the program is appropriate, based on the patient's diagnosis; and,

iii. Includes certification (signed statement) by the evaluation team that the program is appropriate to meet the patient's treatment needs; and,

iv. Is made part of the patient's records.

(c) The policy for the evaluation team shall be as follows:

1. The evaluation team for the intake process shall include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified, in accordance with 42 CFR 153).

(d) The policy for the Plan of Care (PoC) shall be as follows:

1. A written individualized PoC shall be developed by the evaluation team for each patient who receives continued treatment. The PoC shall be included in the patient's records and shall be designed to improve the patient's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The PoC shall consist of the following:

i. A written description of the treatment objectives which include the treatment regimen, the specific medical and remedial services, therapies, and activities that will be used to meet the objectives;

ii. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;

iii. A description designation of the type of personnel that will be furnishing the services; and,

iv. A projected schedule for completing reevaluations of the patient's condition and updating the PoC.

(e) Documentation for outpatient psychiatric services shall be as follows:

1. For psychiatric services, the outpatient department shall develop and maintain written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. Such documentation shall include, at a minimum, the following:

i. The specific services rendered, such as individual psychotherapy or family therapy;

ii. The date and the actual time services were rendered;

iii. The duration of services provided, such as 1 hour or ½ hour;

iv. The signature of the practitioner who rendered the services;

v. The setting in which services were rendered; and,

vi. A notation of unusual occurrences or significant deviations from the treatment described in the PoC.

2. Clinical progress, complications, and treatment which affect prognosis and/or progress shall be documented in the patient's medical record at least once a week for partial hospitalization, and at each patient contact or visit for other psychiatric services. Any other information important to the clinical picture, therapy, and prognosis shall also be documented.

i. The individual services provided under partial hospitalization shall be documented on a daily basis. More substantive documentation, including progress notes, and any other information important to the clinical picture shall be made at least once a week.

3. For services requiring prior authorization, such as partial hospitalization (see N.J.A.C. 10:52–2.10), a departure from the PoC requires a new request for prior authorization when a change in the patient's clinical condition necessitates an increase in the frequency and intensity of services, or change in the type of services which will exceed the services authorized.

(f) The policy for periodic reviews shall be as follows:

1. The evaluation team should periodically review the patient's PoC on a regular basis (at least every 90 days) to determine:

i. The patient's progress toward the treatment objectives;

ii. The appropriateness of the services being furnished; and

iii. The need for the patient's continued participation in the program.

2. The periodic reviews should be documented in detail in the patient's records and made available upon request of the Division and/or its agents.

Recodified from N.J.A.C. 10:52–1.15 by R.1998 d.564, effective December 7, 1998.
See: 30 N.J.R. 1257(a), 30 N.J.R. 4225(a).

SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

10:52–2.1 Ambulatory Surgical Center (ASC)

(a) An Ambulatory Surgical Center (ASC) shall be defined as follows:

1. Any distinct entity that operates for the purpose of providing surgical services to patients not requiring hospitalization; and,

2. Has an agreement with the Health Care Financing Administration (HCFA) to participate in the Medicare program; and,

3. Meets specific conditions for coverage set forth in Federal regulations in 42 CFR 416.2, Part B.

(b) An ASC may be operated by a hospital, that is under common ownership or control of a hospital.

1. An ASC operated by a hospital shall be a separately identifiable entity physically, administratively, and financially independent and distinct from other operations of the hospital. For policies and procedures concerning an ASC, see N.J.A.C. 10:66–2, Independent Clinic Services.

i. To apply as a provider of ASC services, contact the Chief, Provider Enrollment, Division of Medical Assistance and Health Services, PO Box 712, Mail Code # 9, Trenton, New Jersey 08625–0712.

10:52–2.2 Blood and blood products

(a) Blood may be provided to an inpatient or an outpatient of an approved hospital when prescribed and supervised by a licensed physician.

(b) Whole blood and derivatives, and necessary processing and administration thereof, are allowed with the following limitations:

1. Efforts should be made to arrange for the replacement of blood. This can be done by contribution of a blood donor or by using a blood replacement plan that includes the Medicaid recipient as a beneficiary (if available).

2. The cost of donated blood or blood products (including autologous donation) received through a replacement plan is not reimbursable. However, the charge for phlebotomy, cross-matching, indexing, storage and transfusing is reimbursable.

3. The hospital shall obtain a certification that a voluntary blood donation cannot be obtained, in order to be reimbursed.

i. When arrangements for payment for the replacement of blood are not accomplished, reimbursement to the hospital shall be 100 per cent of the "add-on" charge.

10:52–2.3 Dental services

(a) Dental services in the outpatient department shall follow the policies and procedures outlined in N.J.A.C. 10:56, Dental Services. The outpatient dental department shall be subject to the same policies and procedures that apply to the Medicaid provider of dental services in the community, except for emergency dental care provided under special circumstances in a hospital emergency room.

1. A hospital with an outpatient dental department serving Medicaid recipients is given a unique provider number for that department. A hospital that starts an outpatient dental department shall request a provider number for that department from the fiscal agent.

(b) Reimbursement for a dental service is determined by the Commissioner of the Department of Human Services in accordance with N.J.A.C. 10:56, and is based on the same fee, conditions and definitions for the corresponding service, utilized for the payment of individual Medicaid dental practitioners and providers in the community. In no event shall the charge to the Division exceed the charge by the provider for identical services to other groups or individuals in the community.

1. If a dental procedure code is assigned both a specialist and non-specialist "Maximum Fee Allowance Schedule", the amount of the payment will be based upon the status (specialist or non-specialist) of the individual practitioner who actually provided the billed service.

i. If the dentist providing the services is a resident, intern, or house staff member, the status of the supervising dentist, specialist or non-specialist, determines the amount of the payment.

2. Covered emergency dental care performed in the hospital emergency room shall not be reimbursed if the services were provided in the emergency room and the dental clinic was available at the same time.

10:52–2.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive health program for Medicaid recipients from birth through 20 years of age. The goal of the program is to assess the recipient's health needs through initial and periodic examinations (screenings); to provide health education and guidance; and to assure that health problems are prevented, diagnosed, and treated at the earliest possible time.

1. As a condition of participation in Medicaid, all ambulatory care facilities (including hospital outpatient departments) providing primary care to children and adolescents from birth through 20 years of age, shall participate in the EPSDT program and shall provide, at a minimum, the required EPSDT screening services. The required EPSDT services include the following:

2. HealthStart is a program of enhanced maternity care and preventive health care for children under 2 years of age. Certified Pediatric HealthStart providers agree to assure continuity of care by following up on referrals and missed appointments, making available 24 hour telephone access and sick care, either directly or by formal arrangement with another pediatric provider. EPSDT providers may apply to the New Jersey Department of Health for certification as Pediatric HealthStart providers.

i. Pediatric HealthStart providers shall be approved for a higher reimbursement for preventive child health examinations (screenings) than other EPSDT providers, in accordance with N.J.A.C. 10:52–3.

ii. For policies and procedures for HealthStart, see also N.J.A.C. 10:52–3.

(b) EPSDT/HealthStart screening services shall be billed on the Report and Claim for EPSDT/HealthStart Screening and Related Procedure Form using EPSDT/HealthStart specific procedure codes as listed in N.J.A.C. 10:66–6.3(a) in Independent Clinic Services. Claims shall be submitted within 30 days of the date of service for EPSDT services.

(c) The required EPSDT services shall include the following:

1. Screening services, the components of which are described in (e)1 below:

2. Vision services;

3. Dental services;

4. Hearing services; and,

5. Other medically necessary health care, diagnostic services and treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

i. For the policy related to prior authorization of organ procurement and transplantation for Medicaid recipients receiving EPSDT services, see N.J.A.C. 10:52–2.8(e) under organ procurement and transplantation services.

ii. For the policy related to private duty nursing services in the home care setting for EPSDT recipients, see N.J.A.C. 10:60.

6. The parameters used in assessing the recipient's developmental level and behavior shall be appropriate for the age. While no specific test instrument is endorsed, it is expected that an evaluation of a young child shall, at a minimum, address the gross and fine motor coordination, language/vocabulary and adaptive behavior. An assessment of a school age child should include school performance; peer relationships; social activity and/or behavior; physical and/or athletic aptitude; and sexual maturation.

(d) EPSDT screening, vision services, dental services, and hearing services shall be provided at defined intervals as recommended by the appropriate professional organizations.

(e) EPSDT Screening Services shall be provided as follows:

1. The components of EPSDT Screening Services are as follows:

i. A comprehensive health and developmental history including an assessment of both physical and mental health development;

ii. A comprehensive unclothed physical examination including vision and hearing screening, dental inspection and nutritional assessment;

iii. Appropriate immunizations according to age and health history;

iv. Appropriate laboratory tests, including:

(1) Hemoglobin or hematocrit;

(2) Urinalysis;

(3) Tuberculin skin test, intradermal, administered annually and when medically indicated;

(4) Lead screening using blood lead level determinations between 6 and 12 months, at 2 years of age, and annually up to 6 years of age. At all other visits, screening shall consist of verbal risk assessment and blood lead level testing, as indicated.

(5) Additional laboratory tests which may be appropriate and medically indicated (e.g. for oval and parasites) shall be obtained, as necessary.

v. Health education including anticipatory guidance.

vi. Referral for further diagnosis and treatment or follow-up of all correctable abnormalities, uncovered or suspected. Referral may be made to the provider conducting the screening examination or to another provider, as appropriate.

vii. Referral to the Special Supplemental Food Program for Women, Infants and Children (WIC) is required for children under 5 years of age and for pregnant or lactating women.

2. EPSDT Screening Services shall be provided periodically according to the following schedule which reflects the age of the child:

i. Under six weeks; two months; four months; six months; nine months; 12 months; 15 months; 18 months; 24 months; and, annually through age 20.

(f) Vision services shall include the following:

1. A newborn examination including general inspection of the eyes, visualization of the red reflex, and evaluation of ocular motility;

2. An appropriate medical and family history;

3. An evaluation, by age six months, of eye fixation preference, muscle imbalance, and pupillary light reflex; and

4. A third examination with visual acuity testing by age three or four years.

5. Periodicity of testing for school aged children shall be as follows:

i. Kindergarten or first grade (five or six years);

ii. Second grade (seven years);

iii. Fifth grade (10/11 years);

iv. Eighth grade (13/14 years); and

v. Tenth or eleventh grades (15/17 years).

6. Children should be referred if they:

i. Cannot read the majority of the 20/40 line before their fifth birthday;

ii. Have a two-line difference of visual acuity between the eyes;

iii. Have suspected strabismus; or

iv. Have an abnormal light or red reflex.

(g) Dental services shall include the following:

1. An intraoral examination which is an integral part of a general physical examination, including observation of tooth eruption, occlusion pattern, and presence of caries or oral infection;

2. A formal referral to a dentist is recommended at one year of age; it is mandatory for children three years of age and older; and

3. Dental inspection and prophylaxis that should be carried out every six months until 17 years of age, then annually.

(h) Hearing services shall include the following:

1. Hearing screening, which includes, at a minimum, an observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child. An objective audiometric test, such as a pure tone screening test, if performed as part of an EPSDT screening examination, is eligible for separate reimbursement;

2. An individual hearing screening which should be administered annually to all children through age eight and to all children at risk of hearing impairment; and

3. After eight years of age, children shall be screened every other year in addition to what is required in (h)2 above.

10:52–2.5 Home health agencies; hospital-based

(a) A home health agency (hospital-based) shall be licensed by the New Jersey State Department of Health; certified as a home health agency under Title XVIII (Medicare); possesses a valid and current provider agreement from the Division; and be an identifiable part of a hospital.

(b) The provision of home health care services can range from a complex concentrated professional program (for acute care cases) which would require the services of a public health nurse, registered professional nurse, a licensed practical nurse, physical therapist, occupational therapist, speech-language pathologist, social worker, and homemaker/home health aide to a less complex program (as in chronic care cases) involving a homemaker/home health aide, personal care assistant and/or therapist and minimal visits by a registered nurse. The types of services provided, the frequency and the duration of these services are determined by the needs of each recipient. Only medically necessary home health services are reimbursed by the Division.

(c) Policies and procedures related to Home Health Agencies (Hospital-based) are located in N.J.A.C. 10:60, Home Care Services. A hospital wishing to become a provider of home health services should contact the Chief, Provider Enrollment Unit, Division of Medical Assistance and Health Services, CN–712, Mail Code # 9, Trenton, New Jersey 08625–0712.

10:52–2.6 Medical day care centers; hospital affiliated

(a) A Medical Day Care Center shall be affiliated and identified as part of a hospital which is licensed by the New Jersey State Department of Health, in accordance with its Manual of Standards for Licensure of Adult Day Health Care Facilities and which possesses a valid and current provider agreement from the Division.

(b) Medical Day Care is a program of medically supervised, health related services provided in a hospital affiliated ambulatory care setting to persons who are non-residents of the facility, who do not require 24 hour inpatient institutional care and yet, due to their physical and/or mental impairment, need health maintenance and restorative services supportive to their community living.

(c) A hospital affiliated Medical Day Care Center shall be paid a negotiated per diem rate which shall not exceed the maximum medical day care per diem rate paid to a Medical Day Care Center based in a nursing facility.

1. The per diem rate shall include all required services except for physical therapy and speech-language pathology services, which shall be billed separately.

2. Occupational therapy and transportation services shall be included in the per diem rate paid for medical day care services. Medical day care transportation services shall not be reimbursed by the fiscal agent as a separate service.

3. All direct and indirect costs associated with hospital affiliated Medical Day Care Centers shall be reported separately on New Jersey State Department of Health cost filings for payment purposes and shall not be considered an allowable cost under the DRG reimbursement system.

(d) The Division shall not reimburse for medical day care services and partial hospitalization services provided to the same recipient on the same day.

(e) Policies and procedures related to medical day care are found in N.J.A.C. 10:65, Medical Day Care Services. A hospital wishing to become a provider of medical day care services should contact the Chief, Provider Enrollment Unit, Division of Medical Assistance and Health Services, CN–712, Mail Code # 9, Trenton, New Jersey 08625–0712.

10:52–2.7 Narcotic and drug abuse treatment centers; free-standing

(a) Services provided by a free standing hospital affiliated narcotic and drug abuse treatment center shall be covered only if those services are eligible for Federal Financial Participation under the Medicaid Program (Title XIX of the Social Security Act) and the following conditions are met:

1. The treatment is prescribed by a physician; and,

2. The treatment is provided in a narcotic and drug abuse treatment center licensed or approved by the New Jersey State Department of Health pursuant to N.J.S.A. 26:2G–21 et seq.; and,

3. The staff of the treatment center includes a medical director.

(b) Payment for outpatient services provided in a free-standing narcotic and drug abuse treatment center shall be made on a fee-for-service basis. The services include mental health services, methadone maintenance, and other related health services. The Division's payment shall be accepted as payment in full.

(c) Approved centers shall submit claims only for those procedure codes which correspond to the allowable services included in their New Jersey Medicaid provider approval letter. Room, board and other residential services shall not be covered. Claims for reimbursement shall be submitted to the fiscal agent on the claim form used by independent clinics (1500 N.J.–Health Insurance Claim Form).

10:52–2.8 Organ procurement and transplantation services

(a) The Division covers services rendered and items dispensed or furnished in connection with organ procurement and transplantation services of kidney, heart, heart-lung, liver, bone marrow, cornea and other selected medically necessary organ transplants except for those transplants categorized as experimental. (See (e) below for organ procurement and transplantation.)

(b) Hospitals that perform organ transplants (with the exception of bone marrow transplants and corneas) must meet the following requirements for participation in the Medicare and Medicaid programs.

1. Payment for transplant services and organ procurement services rendered to or items dispensed or furnished a donor will be considered a charge on behalf of the Medicaid recipient.

(c) Federal organ procurement service requirements are listed in the Social Security Act, Section 1138 as amended by Section 9318(a) of the Omnibus Budget Reconciliation Act of 1986.

1. Organ procurement services, with the exception of bone marrow transplant and cornea procurement services, are covered only when the Organ Procurement Organization (OPO) meets the requirements as outlined in the Section 1138 of the Social Security Act (42 U.S.C. 1320(b)–8 Note) and when the OPO is designated and certified by the Secretary of the Department of Health and Human Services as the OPO for that geographical area in which the hospital is located.

(d) The covered organ transplantation procedures shall be performed in an organ transplant center approved or certified by a nationally recognized certifying or approving body, or one designated by the Federal government. In the absence of such a certification or approval of a nationally recognized body, the approval or certification, whichever applies, shall have been obtained from the appropriate body so charged in the State in which the organ transplant center is located.

(e) The candidate for transplantation shall have been accepted for the procedure by the transplant center. Such acceptance shall precede a request for prior authorization from the medical staff in the Office of Medical Affairs and Provider Relations, if applicable. All out-of-State hospitalizations for transplantations shall require prior authorization from the MDO of the recipient's county of residence (see N.J.A.C. 10:49–6.2, Administration.) Prior authorization shall also be required for hospitalizations for procurement and transplantation services for Medicaid recipients for anatomical sites not explicitly listed in (a) above, or previously considered experimental.

(f) Organ transplantations shall be medically necessary. Transplantations, with the exception of cornea transplantations, shall be performed only to avert a potentially life-threatening situation for the patient.

1. If all factors pertinent to decision-making concerning the site of performance of a transplant procedure are essentially equal, preference shall be given to a New Jersey transplant center. However, Medicaid policy of equitable access also applies (see 42 CFR 431.52(c)).

(g) Hospital inpatient services for an out-of-State organ procurement and transplantation shall require approval by the Medicaid District Office and shall be reimbursed according to the policies in the section on the Basis of Payment—Out-of-State Hospital Services in N.J.A.C. 10:52–4.4.

10:52–2.9 Psychiatric services; partial hospitalization

(a) Partial Hospitalization (PH) means a psychiatric service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. A PH program shall provide, as listed below, a full system of services necessary to meet the comprehensive needs of the individual Medicaid recipient. These services shall include:

1. Assessment and evaluation;
2. Service procurement;
3. Therapy;
4. Information and referral;
5. Counseling;
6. Daily living education;

7. Community organization;

8. Pre-vocational therapy;

9. Recreational therapy; and,

10. Health-related services.

(b) Pre-vocational therapy, recreational therapy, and health related services, as required in (a) above, may be provided directly or arranged by partial hospitalization staff through other programs' elements or agencies. To avoid duplication of payment, these services shall not be billed separately from the claim submitted for partial hospitalization reimbursement.

(c) The requirements of the PH program shall include the following:

1. PH shall serve ambulatory, non-residential patients who spend only a part of a 24–hour period (a minimum of three hours of participation in active programming for a half day program exclusive of meals and a minimum of five hours of active participation in active programming for a full day program exclusive of meals) in the hospital.

i. Day, evening, or night care (night care shall include overnight stay) shall not require prior authorization from the Division for the first 90 calendar days from the first date of treatment.

2. A PH program shall be available daily for five days a week, with additional planned activities each week, during evening and/or weekend hours, as needed. Individual clients need not attend every day but as needed.

3. The staff of the PH program shall include a director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field, with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the PH program, on a regularly scheduled basis. Other staff deemed necessary to implement a PH program shall include qualified mental health professionals, para-professionals, and volunteers.

(c) Prior authorization for PH from the Division shall be required after the first 90 calendar days from the date of the initial treatment. Each prior authorization for PH shall be granted for a maximum period of six months. Additional authorizations may be requested.

1. A detailed explanation and a new prior authorization request for PH is required when a departure from the PoC is made because a change in the patient's clinical condition necessitates an increase in the frequency, duration, and intensity of services, or a change in the type of services which will exceed the services authorized.

2. When prior authorization is required, the request shall be submitted on the form, "Request for Authorization of Mental Health Services (FD–07)" to the Psychiatric Consultant, Mental Health Services, Office of the Medical Affairs and Provider Services, Division of Medical Assistance and Health Services, CN–712, Mail Code # 18, Trenton, New Jersey 08625–0712.

3. The request shall include the diagnosis, as set forth in the "(Annotated) International Classification of Diseases, 9th Revision, Clinical Modifications, (ICD–9–CM)", a brief clinical history; present clinical status; and the treatment plan. A request for retroactive authorization will be considered only when the request has been delayed by circumstances beyond the control of the outpatient department.

4. The notification of the disposition (approved, modified, denied, or suspended) of the prior authorization request will be made by the Medicaid fiscal agent. When submitting a claim for reimbursement, the prior authorization number shall be provided on the UB–92 hospital claim form, in order for the claim to be paid by Medicaid.

5. The Division shall not reimburse a hospital for partial hospitalization and medical day care center services provided to the same recipient on the same day.

6. The Division also shall not reimburse a hospital for any mental health service (including medication management) in addition to partial hospitalization services provided to the same recipient on the same day.

10:52–2.10 Rehabilitative services; hospital outpatient department

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

1. "Rehabilitative services" means physical therapy, occupational therapy, speech-language pathology and audiology services, and the use of such supplies and equipment as are necessary in the provision of such services.

2. "Occupational therapy" means services prescribed by a physician and provided to a Medicaid recipient by or under the direction of a qualified occupational therapist. These services include necessary supplies and equipment.

3. "Occupational therapist" means an individual who is:

i. Registered by the American Occupational Therapy Association (AOTA); or,

ii. A graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association. If treatment and/or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure, if applicable, and shall also meet all applicable Federal requirements.

4. "Physical therapy" means services prescribed by a physician and provided to a Medicaid recipient by or under the direction of a qualified physical therapist. These services include necessary supplies and equipment.

5. "Physical therapist" means an individual who is:

i. A graduate of a program of physical therapy approved by both the Council on Medical Association of the American Medical Association and the American Physical Therapy Association or its equivalent; and,

ii. Meet all applicable Federal requirements; be licensed by the State of New Jersey; or, if treatment and/or services are provided in a state other than New Jersey, meet the requirements of that state, including licensure, if licensure is required by that state.

6. "Speech-language pathology" and "audiology services" means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech-language pathologist or audiologist. The services include necessary supplies and equipment.

7. "Speech-language pathologist" or "audiologist" means an individual who:

i. Has a certificate of clinical competence from the American Speech–Language–Hearing Association; or,

ii. Has completed the equivalent educational requirements and work experience necessary for the certificate; or,

iii. Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; and,

iv. If practicing in the State of New Jersey, is licensed by the State of New Jersey as a speech-language pathologist or audiologist; or, if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable, and meets all applicable federal requirements.

(b) All treatment services shall be prescribed by a physician (M.D.) or doctor of osteopathy (D.O.) and provided by or under the direction and/or personal supervision of the appropriate qualified practitioner.

(c) When rehabilitative treatment services are prescribed, a plan of treatment shall be kept on file and completed during the Medicaid recipient's initial evaluation visit. The plan of treatment shall be definitive as to type, amount, frequency, and duration, of the rehabilitative services that are to be furnished and shall include the diagnosis and anticipated goals. For example, an order for "treatment three times a week as needed" is not acceptable.

10:52–2.11 Renal dialysis services for end-stage renal disease (ESRD)

(a) A hospital outpatient renal dialysis center shall be approved by the New Jersey State Department of Health to provide renal dialysis treatment for ESRD.

(b) At the beginning of a maintenance course of renal dialysis treatment for ESRD, renal dialysis centers should direct their Medicaid recipient/patient to the Social Security Administration District Office to file an application for Medicare benefits, if applicable.

(c) Renal dialysis services for ESRD and Medicare approved "add-on" costs shall be reimbursable by Medicaid only when the individual is a Medicaid recipient and not a Medicare recipient, or during the time frame when ESRD benefits are not Medicare reimbursable.

1. Medicare coverage usually begins with the first day of the third month after the month in which a maintenance course of renal dialysis services begins. Claims from that date on shall be submitted to Medicare, unless the Medicaid recipient has been denied eligibility for Medicare.

i. Exception: Medicare coverage may begin earlier than the time frame stated above if the individual receives renal transplantation services or participates in a self-dialysis training program.

(d) Reimbursement for hospital inpatient renal dialysis services for ESRD are included in the DRG rate methodology determinations.

10:52–2.12 Sterilization

(a) The Division covers sterilization procedures performed on Medicaid recipients based on 42 CFR 441.250 through 42 CFR 441.258 and related requirements outlined in this section and in the billing instructions contained in the Fiscal Agent Billing Supplement. For sterilization policy and procedures, see (b) through (e) below.

(b) "Sterilization" means any surgical procedure, treatment, or operation, performed for the purpose of rendering an individual permanently incapable of reproducing. Surgical sterilization procedures are considered to be those whose primary purpose is to render an individual incapable of reproducing. Such procedures require the completion of the Federal "Consent Form" for sterilization.

(c) "Consent Form"—(Pursuant to 42 CFR 441.258—Appendix to Subpart F—Specific Requirements for Use) requirements, including time frames to be met and/or documented on the "Consent Form" prior to the sterilization of an individual, follow:

1. The individual shall be at least 21 years of age at the time the consent is obtained;

2. The individual shall not be mentally incompetent. A "mentally incompetent individual" means an individual who has been declared mentally incompetent by a Federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization;

3. The individual shall not be institutionalized. An "institutionalized individual" means an individual who is:

i. Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or,

ii. Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness;

4. The individual shall have voluntarily given informed consent;

5. At least 30 days, but not more than 180 days, shall have passed between the date of informed consent and the date of sterilization, except in the case of emergency abdominal surgery or premature delivery;

i. In the case of emergency abdominal surgery, at least 72 hours shall have passed between the date he or she gave informed consent and date of sterilization;

ii. In the case of premature delivery, informed consent shall have been given at least 30 days before the expected date of delivery and at least 72 hours have passed between the date of informed consent and the date of premature delivery.

6. In the case where a patient desires to be sterilized at the time of delivery, the "Consent Form" shall be signed by the patient no earlier than the 5th month of pregnancy to minimize the possibility of exceeding the 180 day limit.

(d) An individual shall be considered to have given informed consent only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had or has concerning the procedure, provided a copy of the "Consent Form", and provided orally all of the following information or advice to the individual to be sterilized; and,

i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled; and,

ii. A description of available alternative methods of family planning birth control; and,

iii. Advice that the sterilization procedure is considered to be irreversible; and,

iv. A thorough explanation of the specific sterilization procedure to be performed; and,

v. A full description of the discomfort and risks that may accompany or follow the performing of the procedure, including an explanation of type and possible effects of any anesthetic to be used; and,

vi. A full description of the benefits or advantages that may be expected as a result of the sterilization; and,

vii. Advice that the sterilization will not be performed for at least 30 days except for emergency abdominal surgery or premature delivery.

2. Suitable arrangements were made to insure that the information specified above under "Informed Consent" was effectively communicated to any individual who is blind, deaf, or otherwise handicapped; and,

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the "Consent Form" or the language used by the person obtaining consent; and,

4. The individual to be sterilized was permitted to have a witness of his or her own choice present when consent was obtained; and,

5. The requirements of the "Consent Form" were met, that is, its contents, certification, and signatures (see (e) below). The consent form currently in use by the Division is a replica of the form contained in the Federal regulations and shall be utilized by providers when submitting claims. No other consent form shall be permitted, unless approved by the Secretary, United States Department of Health and Human Services. The form is available from the Division's fiscal agent.

(e) Required consent form information, signatures, certification, and dates: In addition to completing all information (name of doctor or clinic the patient received information from, name of the operation to be performed, the patient's birth date, name of the patient, name of the physician who will perform the sterilization, the method, the language used by an interpreter, name and address of the facility the person obtaining consent is associated with, the date of the sterilization and the specific type of operation) in the appropriate spaces provided, the form shall be signed and dated by hand by the person indicated below:

1. "Consent to Sterilization," by the individual to be sterilized, prior to the sterilization operation (in accordance with the time frames specified in (c)5. above.

2. "Interpreter's Statement," by the interpreter, if one was provided prior to the sterilization operation. The interpreter must certify by signing and dating the "Consent Form" that:

i. He or she translated the information presented orally and read the "Consent Form" and explained its contents to the individual to be sterilized; and,

ii. To the best of the interpreter's knowledge and belief, the individual understood what the interpreter told him or her.

3. "Statement of Person Obtaining Consent," by the person who obtained the consent prior to the sterilization operation. The person securing the consent must certify, by signing and dating the "Consent Form" that:

i. Before the individual signed the "Consent Form", he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized; and,

ii. He or she explained orally the requirements for informed consent as set forth on the "Consent Form"; and

iii. To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized. The name and address of the facility or physician's office with which the person obtaining consent is associated must be completed in the space provided on the form.

4. "Physician's Statement," by the physician who performed the sterilization operation after the surgery had been performed. (A date prior to surgery is not acceptable.) The physician performing the sterilization shall certify, by signing and dating the "Consent Form," that within 24 hours before the performance of the sterilization operation:

i. The physician advised the individual to be sterilized that no Federal benefits may be withdrawn from the patient because of the decision not to be sterilized; and,

ii. The physician explained orally the requirements for informed consent as set forth on the "Consent Form"; and,

iii. To the best of the physician's knowledge and belief, the individual appeared mentally competent and knowingly and voluntarily consented to be sterilized; and,

iv. That at least 30 days have passed between the date of the individual's signature on the "Consent Form" and certified that the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature delivery; and,

v. In the case of emergency abdominal surgery or premature delivery performed within 30 days of consent, the physician shall certify that the sterilization was performed less than 30 days, but not less than 72 hours after informed consent was obtained, and in the case of abdominal surgery must describe the emergency, or in the case of premature delivery, must state the expected date of delivery.

5. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

6. Informed consent shall not be obtained while the individual to be sterilized is:

i. In labor or childbirth; or,

ii. Seeking to obtain or obtaining an abortion; or,

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness.

(f) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB–92 claim form (including inpatient or outpatient) for all sterilization claims with the "Consent Form" attached to the UB–92 claim form and not submit the claim through the EMC claim processing system.

10:52–2.13 Hysterectomy

(a) The Division covers hysterectomy procedures performed on Medicaid recipients based on Federal regulations (42 CFR 441.250 through 42 CFR 441.258) and related requirements outlined in this section and in the billing instructions. For hysterectomy policies and procedures, see (b) through (d) below. Also, for the requirements for a Second Surgical Opinion for performing a hysterectomy, see N.J.A.C. 10:52–1.11.

(b) "Hysterectomy" means an operation for the purpose of removing the uterus.

1. A hysterectomy shall not be performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy shall be covered as a surgical procedure if performed primarily for the purpose of removing a pathological organ.

(c) Surgical hysterectomy procedures claim processing and reporting require the completion of the "Hysterectomy Receipt of Information Form (FD–189, Rev. 7/83)" or, under certain conditions (see (d)1.iii. below), a physician certification.

(d) The specific requirements to be met and/or documented on the "Hysterectomy Receipt of Information," (FD–189, Rev. 7/83) form, or, under certain conditions, a physician certification, shall be as follows:

1. A hysterectomy on a female of any age may be performed when medically necessary for a pathological indication, provided the person who secured authorization to perform the hysterectomy has:

i. Informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and,

ii. Ensures that the FD–189 form is completed and the individual or her representative has signed and dated a written acknowledgement of receipt of that information utilizing the FD–189 form; or,

iii. The physician who performed the hysterectomy certifies, in writing, that the individual:

(1) Was sterile before the hysterectomy (include cause of sterility); or,

(2) Required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible (include a description of the nature of the emergency); or,

(3) Was operated on during a period of the person's retroactive Medicaid eligibility and the individual was informed, before the operation, that the hysterectomy would make her permanently incapable of reproducing or one of the conditions described in (1) or (2) above was applicable. (Include a statement that the individual was informed or describe which condition was applicable). "Retroactive Medicaid eligibility" means the consideration of unpaid medical bills incurred during a three month period prior to the month the person applied for assistance. (See N.J.A.C. 10:49–2.7, Administration.) Although a physician certification is acceptable for situations described in (d)1iii above, the Division recommends that the FD–189 form be used whenever possible. There is no 30 day waiting period required before a medically necessary hysterectomy may be performed. The standard procedure for a surgical informed consent form within the hospital will prevail.

(e) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB–92 claim form for all hysterectomy claims with the FD–189 form attached to the claim form and must not submit the claim through the EMC claim processing system.

10:52–2.14 Termination of pregnancy

(a) The Division shall reimburse for medically necessary termination of pregnancy procedures on Medicaid recipients when performed by a physician in accordance with N.J.A.C. 13:35–4.2.

(b) A physician may take the following factors into consideration in determining whether a termination of pregnancy is medically necessary:

1. Physical, emotional, and psychological factors;
2. Family reasons; and,
3. Age.

(c) The determination of medical necessity is subject to review by Medicaid in accordance with the rules of the Medicaid program. In addition, the procedure must be performed consistent with N.J.A.C. 13:35–4.2.

(d) A "Physician Certification (Form FD–179)" shall be attached to the hospital's Medicaid claim form, either for inpatient or outpatient services, if any of the procedures on the claim relate to a voluntary elective abortion.

i. A copy of the completed FD–179 shall also be attached to:

(1) The physician's Medicaid claim form; and,

(2) The anesthesiologist's Medicaid claim form.

(e) Any New Jersey hospital with electronic billing capabilities shall submit a "hard copy" of the UB–92 claim form (inpatient or outpatient) for all termination of pregnancy claims with the "Physician Certification (Form FD–179)" attached to the UB–92 claim form and must not submit the claim through the electronic billing system.

10:52–2.15 Transportation services; hospital-based

(a) Transportation shall be recognized by the Division as a covered outpatient hospital service under the following conditions:

1. Hospital-based emergency ambulance service for inpatient admission or outpatient services. For the definition of "emergency conditions", see N.J.A.C. 10:49–6.1, Administration, Prior and Retroactive Authorization.

2. Non-emergency ambulance service, only when it is ordered by a physician and is medically necessary. A physician's written order stating that any other method of transportation is medically contraindicated shall accompany the claim.

3. When a hospital is under contract with a municipality, county, or other government unit, to provide "911" or rescue squad ambulance service, reimbursement shall only be permitted on a fee-for-service basis under the policies and procedures as defined in N.J.A.C. 10:50–1.2, Transportation Services.

4. Each hospital providing ambulance service to Medicaid recipients shall possess all of the following:

i. An approved certificate of need for ambulance service from the New Jersey State Department of Health; and,

ii. A provider license and vehicle license(s) for ambulance service from the New Jersey State Department of Health.

(b) Mobile Intensive Care Unit/Advanced Life Support (MICU/ALS) service and associated Ambulance/Basic Life Support (Ambulance/BLS) service shall be considered covered services under the following conditions of participation:

1. A hospital shall possess a "Certificate of Need" from the New Jersey State Department of Health to provide MICU/ALS service;

2. A hospital shall complete a "Memorandum of Understanding", issued by the Division of Medical Assistance and Health Services, before reimbursement can be made to the hospital for this service. The "Memorandum of Understanding" may be obtained from and, when completed, shall be returned to the Division of Medical Assistance and Health Services, Provider Enrollment Unit, CN–712, Mail Code # 9, Trenton, New Jersey 08625–0712;

3. A hospital providing MICU/ALS service without its own associated Ambulance/BLS service or MICU/ALS transport vehicle, may utilize the service of a volunteer ambulance organization or shall enter into an agreement(s) with a proprietary/nonproprietary Ambulance/BLS company for the purpose of defining the responsibility for service. No reimbursement shall be made when the Ambulance/BLS service is provided by a volunteer ambulance organization.

i. A copy of the agreement(s) shall be sent to the Division of Medical Assistance and Health Services, CN–712, Provider Enrollment Unit, Mail Code # 9, Trenton, New Jersey 08625–0712.

ii. The hospital shall bill for the Ambulance/BLS service only upon completion of an agreement.

iii. In the absence of an agreement(s) between the hospital providing the MICU/ALS service and a proprietary/nonproprietary Ambulance/BLS company, the hospital shall bill the Division's fiscal agent for the MICU/ALS service only.

iv. Transportation companies providing Ambulance/BLS associated with, and/or in conjunction with a MICU/ALS service, shall bill charges to the hospital providing the MICU/ALS service.

(c) Medicaid reimbursement of MICU/ALS services shall be based on Medicare principles of reimbursement, using standard cost reporting procedures, and reasonable cost and charge guidelines.

(d) Reimbursement for transportation services to and from hospital affiliated medical day care centers are included in the medical day care per diem rate.

SUBCHAPTER 3. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES

10:52–3.1 Purpose

The purpose of HealthStart shall be to provide comprehensive maternity and child health care services for all pregnant women (including those determined to be presumptively eligible) and for children (under two years of age) in the State of New Jersey who are eligible for Medicaid benefits.

10:52–3.2 Scope of services

(a) HealthStart maternity care services shall include all medical services recommended by the American College of Obstetricians and Gynecologists, as well as a program of health support services. HealthStart pediatric care services shall include the nine preventive visits recommended by the American Academy of Pediatrics and all of the necessary immunizations. This subchapter includes provisions for provider participation, standards for service delivery, procedure codes from the HCFA Common Procedure Coding System (HCPCS), and directions for submitting claims.

(b) HealthStart Comprehensive Maternity Care includes two components; Medical Maternity Care Services and Health Support Services, as follows:

1. Medical Maternity Care Services include, but are not limited to:

i. Ambulatory prenatal services;

ii. Admission arrangements for delivery;

iii. Obstetrical delivery services; and

iv. Postpartum medical services.

2. Health Support Services include, but are not limited to:

i. Case coordination services;

ii. Health education assessment and counseling services;

iii. Nutrition assessment and counseling services;

iv. Social-psychological assessment and counseling services.

v. Home visitation; and

vi. Outreach, referral and follow-up services.

(c) HealthStart Comprehensive Pediatric Care includes nine preventive child health visits, all the recommended immunizations, case coordination and continuity of care, including, but not limited to, the provision or arrangement for sick care, 24–hour telephone access, and referral and follow-up for complex or extensive medical, social, psychological, and nutritional needs.

10:52–3.3 HealthStart provider participation criteria

(a) Providers that are eligible to participate as HealthStart providers shall be: independent clinics (including local health departments meeting the New Jersey Department of Health Improved Pregnancy Outcome and/or Child Health Conference criteria); hospital outpatient departments; physicians and physician groups; and nurse midwives approved as providers in the New Jersey Medicaid program, in accordance with N.J.A.C. 10:58 and 10:49.

(b) In addition to New Jersey Medicaid program rules applicable to provider participation, HealthStart providers shall:

1. Sign an Addendum to the New Jersey Medicaid Program Provider Agreement;

2. Have a valid HealthStart Maternity Care Certificate and/or a Pediatric Care Certificate; and

3. Provide maternity care and/or pediatric care services in accordance with the requirements for issuance of a "HealthStart Maternity Care Certificate", and/or a "HealthStart Pediatric Care Certificate", and in accordance with the New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers and HealthStart Pediatric Care Providers.

(c) In addition to (a) and (b) above, HealthStart Maternity Care Providers with more than one care site or more than one maternity clinic at the same site that uses different staff, shall apply for a separate HealthStart Maternity Care Certificate for each separate clinic. Within an agency, only those sites which hold a certificate shall be reimbursed for HealthStart services; and

1. Shall participate in program evaluation and training activities, including but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to the New Jersey Department of Health Guidelines for HealthStart Providers; and

2. May determine presumptive eligibility for New Jersey Medicaid if approved by the Division of Medical Assistance and Health Services.

(d) In addition to (a) and (b) above, HealthStart Pediatric Care Providers shall participate in program evaluation and training activities, including, but not limited to, documentation of outreach and follow-up activities in the patient's record.

(e) Site reviews may be required to ascertain applicant's ability to meet the Standards for HealthStart Certificates in appropriate areas and to provide services in accordance with the New Jersey State Department of Health Guidelines for HealthStart Providers in appropriate areas.

(f) HealthStart Provider Certificates shall be reviewed at least every eighteen months from the date of issuance.

(g) Applications for HealthStart Provider Certificates are available from:

HealthStart Project
New Jersey Department of Health
CN 360
Trenton, NJ 08625–0360

(h) Applications for New Jersey Medicaid Provider agreements are available from:

Unisys Corporation
Provider Enrollment
P.O. Box 4804
Trenton, New Jersey 08650–4804

10:52–3.4 Termination of HealthStart certificate

(a) The New Jersey State Department of Health shall be responsible for enforcement of its requirements for HealthStart provider Certificates and for evaluation and enforcement of its requirements within the Standards and Guidelines for HealthStart providers.

(b) Failure to comply with HealthStart Certificate Standards shall be cause for termination of the HealthStart provider certificate. Providers who are terminated shall have the right to request a hearing pursuant to the procedures in N.J.A.C. 10:49–10.10.

10:52–3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate

(a) Comprehensive maternity care services shall be integrated and coordinated.

(b) HealthStart Maternity Care providers, excluding physicians and nurse midwives who are in private practice, shall be required to provide for comprehensive maternity care services within the following organizational requirements.

1. Providers shall provide directly or through approved agreements, at one contiguous site, the following services: ambulatory prenatal and postpartum care; case coordination services; nutrition assessment; guidance and counseling services; health education assessment and instruction; social-psychological assessment, guidance and counseling;

2. Providers shall provide or arrange for the admission of patients to the appropriate level of care facility for obstetrical care delivery services;

3. Providers shall provide or arrange for all necessary laboratory services;

4. Providers shall provide one or more prenatal home visits for each high risk patient;

5. Providers shall provide at least one postpartum home visit for each high risk patient;

6. Providers shall provide referral and follow-up services, which shall include but not be limited to: referral for specialized evaluation; and counseling and treatment for extensive social, psychological, nutrition and medical needs.

(c) Providers shall adopt procedures and policies which assure the delivery of coordinated, integrated and comprehensive care; and

(d) Providers shall be responsible for linking the mother and newborn infant to a pediatric care provider; if feasible, the linkage shall be with a HealthStart Pediatric Care provider.

(e) Independent clinics, hospital outpatient departments, and local health departments may provide just the HealthStart Health Support Services Component only when they have entered into a written agreement with a private practitioner(s) who will provide the HealthStart Medical Care Services component. This agreement shall delineate which party shall take primary responsibility for provision of all HealthStart services.

10:52–3.6 Access to services

(a) All HealthStart services shall be accessible to patients.

(b) HealthStart Maternity Care providers shall facilitate patient access to services by scheduling an initial appointment within two weeks of the patient's first request for services.

(c) HealthStart Maternity Care providers shall provide or arrange for 24 hour access to case coordination and medical services for emergency situations.

(d) HealthStart Maternity Care providers shall arrange for language translation and/or interpretation services.

(e) HealthStart Maternity Care providers may implement presumptive eligibility determinations if approved by the Division of Medical Assistance and Health Services to institute this process.

(f) HealthStart Maternity Care providers shall undertake community outreach activities to encourage women to seek early prenatal care and increase awareness of the availability of maternity care services.

10:52–3.7 Plan of Care (PoC)

(a) A PoC shall be developed and maintained by the case coordinator for each patient.

(b) A PoC shall be based on the medical, nutritional, social-psychological and health education assessments.

(c) A PoC shall include but not be limited to: identification of risk conditions and/or problems, prioritization of needs, outcome objectives, planned interventions, time frames, referrals and follow-up activities, and identification of staff persons responsible for the services.

(d) The PoC shall be developed and revised in consultation with the patient and staff providing services to the patient.

(e) The initial PoC shall be completed after a case conference and no later than one month after the initial registration visit.

10:52–3.8 Maternity Medical Care services

(a) Maternity Medical Care services shall include antepartum, intra-partum and post-partum care provided by the obstetrical care practitioner(s) in accordance with New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers.

(b) Prenatal services are as follows:

1. Frequency of prenatal visits for an uncomplicated pregnancy shall be every four weeks during the first twenty-eight weeks; then every two weeks until thirty-six weeks; and weekly thereafter. Prenatal visits for complications should be scheduled as needed.

2. Initial prenatal visit content shall include, but not be limited to, the following:

i. History;

ii. Review of systems;

iii. Comprehensive physical examination;

iv. Risk assessment;

v. Patient counseling;

vi. Routine laboratory tests;

vii. Development of the PoC; and

viii. Special tests and/or procedures as medically indicated.

3. Subsequent prenatal visit content shall include, but not be limited to the:

i. Review and revision of the patient PoC;

ii. Interim history;

iii. Physical examination;

iv. Patient counseling and treatment;

v. Laboratory tests;

vi. Special tests and/or procedures which are medically indicated;

vii. Identification of new or developing problems; and

viii. Management of any new or persistent problems including transfers.

4. Transfer of prenatal records to the hospital of delivery no later than thirty-four (34) weeks gestation.

(c) Obstetrical delivery services shall include, but not be limited to, the following:

1. Determination of, and arrangements for, delivery site;

2. Attendance at or provision for obstetrical delivery by a qualified physician or certified nurse midwife; and

3. Medical treatment during the postpartum stay.

(d) A postpartum visit shall be provided by the 60th day after delivery, and shall include, but not be limited to, the following:

1. History;
2. Review of the prenatal, labor and delivery record;
3. Physical examination;
4. Patient counseling and treatment;
5. Parent/infant assessment;
6. Referral/consultation, as indicated; and
7. Procedures/tests, as indicated.

(e) All HealthStart Maternity Care providers shall have policies and protocols consistent with national standards regarding consultation, and/or transfer of medically high risk patients to tertiary level maternity care facilities or specialists, and to genetic counseling and testing facilities.

10:52–3.9 HealthStart Health Support services

(a) Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers", as follows:

1. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit.

2. Prenatal case coordination activities shall include but not be limited to:

i. Orienting the patient to all services;

ii. Developing, maintaining and coordinating the PoC in consultation with the patient;

iii. Coordinating and monitoring the delivery of all services and referrals;

iv. Monitoring and facilitating the patient entry into and continuation with maternity services;

v. Facilitating and providing advocacy for obtaining referral services;

vi. Reinforcing health teachings and providing support;

vii. Providing vigorous follow-up for missed appointments and referrals;

viii. Arranging home visits;

ix. Meeting with the patient and coordinating patient care conferences; and

x. Reviewing, monitoring and updating the patient's complete record.

3. Postpartum case coordination activities shall include, but not be limited to, the following:

i. Arranging and coordinating the postpartum visit and any home visit;

ii. Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record no later than two weeks after delivery;

iii. Linking the patient to appropriate service agencies including: Women, Infants and Children Program (WIC), pediatric care (preferably with a HealthStart Pediatric Care provider), future family planning, Special Child Health Services County Case Management Unit and other health and social agencies, if needed:

iv. Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;

v. Coordinating referrals and following up on missed appointments and referrals;

vi. Reinforcing health instruction for mother and baby.

(b) Nutrition assessment and basic guidance services shall be provided to orient and educate patients to nutritional needs during pregnancy and to educate patients to good dietary practices in accordance with "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers". Specialized nutrition assessment and counseling must be provided to women with additional needs. Services shall be provided as follows:

1. Initial assessment services, which shall include but are not limited to, the following:

i. Review of the patient's chart;

ii. Identification of dental problems which may interfere with nutrition;

iii. Nutrition history;

iv. Current nutritional status;

v. Determination of participation in WIC or other food supplement programs; and

vi. Identification of need for specialized nutrition counseling;

2. Subsequent nutrition assessment, which shall include but not be limited to, the following:

i. Monitoring of weight gain/loss;

ii. Identification of special dietary needs; and

iii. Identification of need for specialized nutrition counseling services;

3. Prenatal nutrition basic guidance, which shall include but not be limited to, the following:

i. Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;

ii. Review and reinforcement of other nutrition and dietary counseling services the patient may be receiving;

iii. Instruction on food purchase, storage and preparation;

iv. Instruction on food substitutions, as indicated;

v. Discussion of infant feeding and nutritional needs; and

vi. Referral to food supplementation programs through the case coordinator;

4. Specialized nutrition assessment and counseling, which shall be provided to those women with additional needs;

5. Referral for extensive specialized nutrition services, which shall be initiated by the medical care provider or the nutritionist under the supervision of the medical care provider, in coordination with the case coordinator; and

6. Postpartum nutrition assessment and basic guidance services, which shall include, but not be limited to, the following:

i. Review and reinforcement of good dietary practices;

ii. Review of instruction on dietary requirement changes; and

iii. Instruction on breast feeding and/or formula preparation and feeding.

(c) Social-psychological assessment and basic guidance services shall be provided to all patients to assist each patient in resolving social-psychological needs, as described in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers." Specialized social-psychological assessment and short-term counseling shall be provided to those women with additional needs. Services shall be provided as follows:

1. Initial social-psychological assessment services, which shall include, but not be limited to, the following:

i. Determining financial resources and living conditions;

ii. Determining the patient's personal support system;

iii. Determining the patient's attitudes and concerns regarding the pregnancy;

iv. Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;

v. Ascertaining educational and/or employment status and needs; and

vi. Identifying the need for specialized social-psychological and/or mental health evaluation and counseling services;

2. Subsequent social-psychological assessment services, which shall include, but not be limited to, the following:

i. Determining patient's reaction to pregnancy;

ii. Ascertaining the reaction of family, friends and the actual support person to the pregnancy;

iii. Identifying the need for social service interventions and advocacy; and

iv. Identifying the need for specialized social-psychological and/or mental health evaluation and counseling;

3. Basic social-psychological guidance, which shall include, but not be limited to, the following:

i. Orientation and information on available community resources;

ii. Orientation regarding stress and stress reduction during pregnancy; and

iii. Assistance with arrangements for transportation, child care and financial needs;

4. Specialized, short-term social-psychological counseling, which shall be provided to women who are identified through assessment or basic counseling as having need for more intense service.

5. Referral for extensive specialized social-psychological services, which shall be initiated by the medical care provider, or by the social worker under the supervision of the medical care provider and in coordination with the case coordinator; and

6. Postpartum social-psychological assessment and guidance, which shall include, but not be limited to, the following:

i. Review of prenatal, labor, delivery and postpartum course;

ii. Assessment of patient's current social-psychological status, including mother and infant bonding and father/family acceptance of the infant, as applicable;

iii. Identification of the need for additional social-psychological services;

iv. Review of available community resources for mother and infant, as applicable;

v. Counseling regarding fetal loss or infant death, if applicable; and

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 as described in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers." Services shall be provided as follows:

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

i. Identification of general educational background;

ii. Identification of patient's health education needs; and

iii. Identification of 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 least 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. Child birth preparation, including management of labor and delivery;

vii. Preparation for hospital admission;

viii. Substance/occupational/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.

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

(e) The provider shall provide, or arrange for, one or more home visits for each high risk patient, as described in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers."

(f) One face to face encounter shall be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit as described in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers," as follows:

1. This contact shall include but 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 PoC; and

v. Provision of additional services, as indicated.

(g) HealthStart Maternity Care Providers shall utilize existing community services to enhance the maternity care services.

(h) 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 shall include but are not 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.

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

(a) All HealthStart Maternity Care services shall be delivered through a team approach by qualified professionals.

(b) Physicians and/or certified nurse midwives shall be Medicaid providers and have obstetrical admitting privileges at a licensed maternity care facility.

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

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

(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 and/or skill in maternal and child health services and be supervised by a health professional.

(g) Prenatal, delivery, and postpartum medical services shall be delivered by physicians and/or certified nurse midwives.

(h) Nutrition, social-psychological and health education assessments and development of PoC 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 portions of the PoCs are provided by case coordinators or medical care professionals, then these portions shall be reviewed by nutritionists or social workers, respectively.

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

(j) Short term specialized social-psychological and nutrition counseling services shall be provided by social workers and nutritionists respectively. Social workers and nutritionists 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.

10:52–3.11 Records; documentation, confidentiality and informed consent requirements for HealthStart Comprehensive 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 as described in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers."

(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 Care Plan, 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 services.

10:52–3.12 Standards for HealthStart Pediatric Care Certificate

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

(b) HealthStart Pediatric Care providers shall be Medicaid providers and shall:

1. Directly provide preventive, well-child 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 to patients.

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

10:52–3.13 Professional requirements for HealthStart Pediatric Care providers

All HealthStart Pediatric Care providers shall be physicians 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 and/or by hospital admitting privileges in pediatrics.

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 and as described in the "New Jersey State Department of Health Guidelines for HealthStart Pediatric Care." 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. The EPSDT/HealthStart Child Health Preventive Visit form (MC–19) shall be completed for each HealthStart preventive visit and submitted within 30 days.

(b) Each provider shall provide or arrange for sick care and twenty-four hour telephone physician access during non-office hours. If not directly provided by the HealthStart provider, sick care and twenty-four 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 shall occur only for emergency medical care or urgent care as recommended by the physician responsible for sick care.

(c) Case coordination outreach and follow-up services shall include letter and/or telephone call reminders to the child's parent or guardian for preventive well-child visits and letters and/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 and/or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and/or 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 is not limited to: the Women, Infants and Children Program (WIC), the Division of Youth and Family Services, Special Child Health Services Case Management Units and Child Evaluation Centers, the early intervention programs, County Welfare Agencies/Board of Social Services, certified home health agencies, community mental health centers, local and county health departments.

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 as described in the "New Jersey State Department of Health Guidelines for HealthStart Pediatric Care Providers."

(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, Care Plan, 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.

10:52–3.16 Policy for reimbursement for HealthStart providers

(a) The HealthStart HCPCS procedure codes listed in this subchapter are governed by the same policies and 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. 10:66–3(a).

(b) A hospital outpatient department (OPD) which is a HealthStart Provider shall use the present procedure for OPD billing (UB–92 claim form; except for:

1. HealthStart Health Support Services (W9040 through W9043), which shall be billed on the 1500 N.J. 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, Report and Claim for EPSDT/HealthStart Screening and Related Procedures.

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 feasible, 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. 10:66–3(a) Health Care Financing Administration (HCFA), Common Procedure Coding System (HCPCS), Independent Clinic Services.

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 9, 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(c).

10:52–4.2 Basis of payment; special hospitals (Classification A and B), private 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) for inpatient ser-

vices (including the interim and final settlement), in accordance with Medicare principles: reimbursement (see 42 CFR 413).

(b) The Division will reimburse special hospitals (Classification C) according to the rules and reimbursement methodology of Chapter 63, Long Term Care Services (N.J.A.C. 10:63).

(c) The Division will reimburse private psychiatric hospitals and distinct units of acute general hospitals for inpatient services (including the interim and final settlement) in accordance with Medicare principles of reimbursement. Distinct units of acute general hospitals are not reimbursed through the Diagnosis Related Groups (DRG) reimbursement system (N.J.A.C. 8:31B) for inpatient services in acute care general hospitals.

(d) Therapeutic leave days (days spent outside the facility) are not reimbursed to hospitals by the Division.

10:52–4.3 Basis of payment; all general and special (Classification A), rehabilitation (Classification B); and private psychiatric hospitals—outpatient services

(a) The Division shall reimburse general hospitals, special hospitals (Classification A), rehabilitation hospitals (Classification B) and private psychiatric hospitals for covered outpatient hospital services provided in outpatient hospital departments approved by the Division as meeting the criteria for participation, in accordance with N.J.A.C. 10:52–1.2A(b) and consistent with the following conditions and reimbursement methodology:

1. Establishment of a final rate of reimbursement: The final rate of reimbursement is based on the lower of cost or charges as defined by Medicare principles of reimbursement at 42 CFR 447.321; and,

2. Establishment of an interim rate of reimbursement: The charge for an outpatient service is subject to a reduction based on the application of a cost-to-charge ratio determined for each individual hospital by the Division, in accordance with Medicare principles of reimbursement at 42 CFR 447.321. This cost-to-charge ratio is used to assure that reimbursement for outpatient services does not exceed the rate based on Medicare principles of reimbursement.

3. Effective for services rendered on or after July 1, 1991 through October 6, 1996, the Division is reducing the interim reimbursement rates for covered outpatient services subject to the cost-to-charge ratio in general, special (Classification A), rehabilitation (Classification B) and private psychiatric hospitals by 4.4 percent. The final settlement for covered outpatient services subject to the cost-to-charge ratio is the lower of costs or charges minus 4.4 percent. Effective for services rendered on and after October 7, 1996, and until further notice, the Division shall reduce hospital outpatient capital cost by 10 percent and reasonable cost of hospital outpatient services (net of the outpatient capital cost) by 5.8 percent as reported in the Medicare Cost Report (HCFA–2552). This reduction shall be calculated when the Medicare Cost Report (HCFA–2552) is finalized and if the report is amended. The reduction shall apply to general, special (Classification A), rehabilitation (Classification B) and private psychiatric hospitals.

(b) Certain outpatient services, that is, most laboratory services, all renal dialysis services, all dental services, some HealthStart services, and the Medicare deductible and coinsurance amounts, are excluded from a reduction based on the cost-to-charge reimbursement methodology and have their own reimbursement methodology as follows:

1. Most outpatient laboratory services are reimbursed on the basis of a fee-for-service using the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) procedure codes and the fee schedule contained in N.J.A.C. 10:52–9.3 through 9.5. If the hospital charge is less than the amount on the fee allowance, reimbursement is based upon the actual billed charge. In addition, there are situations which have unique billing arrangements, as follows:

i. Specimen collection, that is a routine venipuncture for collection of specimen(s) or a catheterization for collection of urine specimen(s) are reimbursed at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day. (See HCPCS G0001, P9610, P9615 in N.J.A.C. 10:52–10.3); and,

ii. Profiles and panels shall be reimbursed as follows:

(1) Profiles are comprised of those components of a test or series of tests performed as groups or combinations (profiles) which are performed on automated multichannel equipment and are finished identifiable laboratory study(ies). Examples are: The components of an SMA (Sequential Multichannel Automated Analysis) 12/60 or other automated laboratory study. Complete blood counts (CBC) with inclusion of Hemoglobin, Hematocrit, Red Blood Cell (RBC) Counts, Red Blood Cell (RBC) indices, White Blood Cell (WBC) Counts, and Differentials, MCHs, MCVs and MCHCs, are calculations, and not billable services. If the components of a profile or panel are billed separately, reimbursement for the components of the profile shall not exceed the Medicaid fee schedule for the profile itself.

(2) Panels are laboratory tests that are associated with other organ or disease oriented areas, such as organ "panels". Examples are hepatic function panels and lipid panels. The tests listed with each panel identifies the defined components of that panel. (See also (b)2iii below.)

2. Some outpatient laboratory services which use laboratory HCPCS procedure codes that are reimbursed based on actual billed charges, are subject to the cost-to-charge ratio. These include procedure codes such as:

i. Those valid for Medicaid reimbursement but not listed on the Medicare Laboratory HCPCS Procedure Code File (see 42 U.S.C. § 1395L). They are designated as "subject to cost-to-charge" or S.C.C. in N.J.A.C. 10:52–9.2;

ii. For those HCPCS codes submitted for payment on the same claim with charges for blood products (if no blood product is provided and/or billed on the same claim, the codes are reimbursed according to the fee allowance schedule); and

iii. For some codes associated with other laboratory services such as for organ or disease oriented panels; clinical pathology consultations; unlisted chemistry or toxicology procedures; certain bone marrow testing; certain specific or unlisted hematology procedures; certain immunology testing; unlisted microbiology procedures; and certain procedures under anatomic pathology.

3. All renal dialysis services for end-stage renal disease (ESRD) are reimbursed at 100 percent of the composite rate and includes any add-on charge to the composite rate approved by Medicare.

i. Renal dialysis services provided on an emergency basis in a hospital center not approved to provide renal dialysis services for ESRD are reimbursed actual billed charges, subject to the cost-to-charge ratio.

4. All dental services are reimbursed in accordance with the Division Dental Fee Schedule. This fee-for-service schedule is consistent with the Division's fees paid to the private practitioners and independent dental clinics. For information about dental services in the Outpatient Department, see N.J.A.C. 10:52–2.3.

5. All HealthStart Maternity Health Support Services and HealthStart Pediatric Continuity of Care services are reimbursed on a fee-for-service basis in the hospital outpatient department. All other HealthStart Maternity and Pediatric Care Services are reimbursed based on the cost-to-charge ratio. (For policies and procedures for HealthStart Services, see N.J.A.C. 10:52–3.10.)

6. Early Periodic Screening, Diagnosis, and Treatment services are reimbursed in the hospital outpatient department according to the specific reimbursement methodology. (See also N.J.A.C. 10:52–2.4.)

i. The physician who is allowed by the hospital to bill Medicaid separately from the hospital costs (unbundled) for EPSDT services, shall bill on the EPSDT form.

7. All deductible and coinsurance amounts for Medicare crossover claims are not subject to the cost-to-charge ratio and are reimbursed are 100 percent of the amounts.

(c) Emergency room visits for Medicaid recipients not admitted as inpatients are coded by the hospital as needing primary care or non-primary care. (See N.J.A.C. 8:31B–3.23(e)).

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 recipient for the reason that such recipient does not require services on an emergency basis.

NOTE: The cost of emergency room services for a Medicaid recipient admitted as an inpatient is allocated to the inpatient rates and is not reimbursed through the outpatient hospital 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).

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 KidCare beneficiaries if the hospital meets the requirements of the Division and the services are prior authorized pursuant to N.J.A.C. 10:52–1.8(c). 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 KidCare 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 recipient 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 program and the hospital performing the organ transplant. 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 KidCare 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).

10:52–4.5 Medicaid reimbursement for third-party claims

On claims for hospital services rendered to Medicaid recipients 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 for covered services. (See N.J.A.C. 10:49–7.3, Administration.)

10:52–4.6 Medicare/Medicaid claims

(a) Some patients may be covered under both Medicare and Medicaid. When the Medicaid recipient is covered under both programs, Item 57 on the hospital claim form shall be completed showing the Medicaid Program Case and Person Number.

(b) Reimbursement of the deductible and coinsurance for inpatient and outpatient services for Medicaid recipients 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 program must be itemized for the Medicare non-covered services and the HSP (Medicaid) Case Number, including Person Number, must be shown on the hospital claim form.

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

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

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

(b) Personal contribution to care for NJ KidCare-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 KidCare-Plan C services if the NJ KidCare Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ KidCare 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 KidCare–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).

10:52–4.8 Medicaid settlement

(a) In the capacity of the New Jersey Medicaid Settlement Agent for hospital for all New Jersey acute care general (excluding inpatient services), special, rehabilitation, private psychiatric and county governmental psychiatric hospitals and all hospital-based home health agencies, Blue Cross and Blue Shield of New Jersey, Inc. (BCBSNJ) shall determine their amount of disbursements, recoupments, and/or changes in per diem amounts and outpatient percentages, as applicable. BCBSNJ shall inform the hospital and the Division of Medical Assistance and Health Services (Division) of the results of their review. If the BCBSNJ'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 20 working days from the date of BCBSNJ's letter.

2. The fiscal agent shall begin recoupment for the full amount of the overpayment 30 days after the date the Division receives BCBSNJ's overpayment notification by withholding the Medicaid payments to the hospital.

3. If the withholding of the New Jersey Medicaid payment 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 Bulletin No. 0452) shall be submitted. If an approvable repayment schedule is not received by the Division, the withholding of Medicaid payments shall be implemented to begin recoupment.

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

Bureau of Institutional and Provider Reimbursement
Division of Medical Assistance and Health Services
PO Box 712, Mail Code # 25
Trenton, New Jersey 08625–0712
Attention: Health Care Facilities Analyst

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 BCBSNJ 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.

SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

10:52–5.1 Derivation of Preliminary Cost Base

(a) [1]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).

[1] So in original.

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 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. 10:52–5.9 through 5.12.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

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 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 in N.J.A.C. 10:52–5.13 through 5.20. 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. 10:52–5.1.

(b) Effective for services provided on or after October 1, 1996, the Director shall develop standard reimbursement amounts for each Diagnosis Related Group based on the median cost per case for Medicaid recipients. The standards shall be adjusted to account for significant differences in labor market areas. These standards are developed according to criteria set in N.J.A.C. 10:52–5.13 through 5.20. 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. 10:52–5.1.

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).

10:52–5.5 (Reserved)

10:52–5.6 Schedule of Rates

(a) In order to determine reasonable physician costs, hospitals shall report to the Director any significant changes in the contractual basis of any and all physician compensation arrangements which have occurred after the correct Cost Base. Failure to report these changes shall result in these costs not being recognized.

(b) For each hospital, the Division shall implement a Schedule of Rates for each Diagnosis Related Group.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

10:52–5.7 Extraordinary expense

If supported by adequate documentation, the Schedule of Rates may include an appropriate adjustment for items of extraordinary expense of a non-recurring nature which occurred in the Current Cost Base and which are reported to the Division by October 15 of the year prior to the issuance of the Proposed Schedule of Rates.

10:52–5.8 (Reserved)

10:52–5.9 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. 10:52–5.17(a);

4. Calculation of the technology factor as described in N.J.A.C. 10:52–5.17;

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).

10:52–5.10 Financial elements reporting/audit adjustments

(a) The aggregate Current Cost Base is developed from Financial Elements reported to the Division and includes:

1. Costs related to Medicaid direct patient care as defined in N.J.A.C. 10:52–6.14;

2. Less net income from specified sources;

3. Capital facilities allowance: Capital cash requirements (as defined in N.J.A.C. 10:52–5.18 and 10:52–6.18);

(b) All reported financial information shall be reconciled by the hospital to the hospital's audited financial statement. In addition, having given adequate notice to the hospital, the Director may perform a cursory or detailed on-site review at the Division's discretion, of all financial information and statistics to verify consistent reporting of data and extraordinary variations in data relating to the development of the rates. Any adjustments made subsequent to the financial review (including Medicare audits and reviews) shall be brought to the attention of the Division by the hospital, the Department of Health, appropriate fiscal intermediary or payer where appropriate and shall be applied proportionately to the Schedule of Rates. All such adjustments shall be determined retroactively to the first payment on the Schedule of Rates and shall be applied prospectively.

10:52–5.11 Identification of direct and indirect costs related to Medicaid patient care

(a) Costs related to Medicaid patient care as adjusted for price level depreciation as reported to the Division shall be classified as follows:

1. Direct patient costs:
   i. Routine service costs;
   ii. Ambulatory service costs; and
   iii. Ancillary service costs.
2. Mixed direct and indirect costs.
3. Indirect patient care:
   i. Institutional costs.

(b) Patient care general service and indirect costs (except as noted below) shall then be distributed to direct cost centers based on allocation statistics reported to the Division on the following basis:

Patient Care General Service		Allocation Basis
CSS:	Central Supply Services	Costed requisitions
DTY:	Dietary	Patient Meals
HKP:	Housekeeping	Hours of Services
L&L:	Laundry and Linen	Pounds of Laundry
MRD:	Medical Records	Percentage of Time Spent
PHM:	Pharmacy	Cost of Drugs
EDR:	Education and Research (not including Schools of Nursing and Allied Health)	Percentage of Time Spent
RSD:	Residents	Accumulated Costs in Patient Care Cost Centers
PHY:	Physicians Coverage (related to research and medical education)	Patient Days
A&G:	Administration and General	Accumulated Cost
FIS:	Fiscal	Accumulated Cost
PCC:	Patient Care Coordination	Percentage of Time Spent
PLT:	Plant (less capitalized interest and depreciation)	Square Feet
UTC:	Utilities Cost	Square Feet
MAL:	Malpractice Insurance	Accumulated Cost
OGS:	Other General Services	Accumulated Cost

10:52–5.12 Patient care cost findings; direct costs per case, physician and nonphysician

(a) Hospital case-mix shall be determined as follows:

1. Uniform Bill–Patient Summary (UB–PS) data shall be used for determination of hospital case-mix. The appropriate patient records for the reporting period corresponding with the Financial Elements Report shall be classified into Diagnosis Related Groups (DRGs) using the following items:

   i. Principal diagnosis;

   ii. Secondary diagnosis;

   iii. Principal and other procedures;

   iv. Age;

   v. Sex;

   vi. Discharge status; and

   vii. Birthweight (newborn).

2. Outliers (patients displaying atypical characteristics relative to other patients, for example, inordinately long or short lengths of stay) shall be determined by DRG using established trim points; any case beyond a trim point is considered an outlier. Hospitals must make every attempt to correct unacceptable data and hospitals for which more than 10 percent of the UB–PS data are missing or unacceptable must resubmit data or correct the unusable data before case-mix estimation will be attempted.

3. Outpatient case-mix shall consist of emergency service, clinic, home health agency, renal dialysis, home dialysis, ambulatory surgery, same day psychiatry, and private referred patients, as reported to the Division.

4. Same Day Surgical Services shall be considered a clinical, outpatient service but are assigned to a DRG and reported on a UB–PS (a bill type 13X).

(b) Measures of resource use are listed as follows:

1. For each patient with a Uniform Bill (UB), measures of resource use shall be calculated to distribute costs among the UB. Measures of resource use represent services provided to patients associated with each cost center. Patient days are associated with routine service cost, emergency room admissions with emergency service cost, and ancillary and therapeutic charges with ancillary and therapeutic service cost. The measures of resource use is a ratio of admissions reported on the hospital's cost report over the hospital's UB billing data. Costs are derived from the Actual Reporting Forms and are associated with admissions. Therefore, an adjustment is made to align the measures of resource use to the inpatient cost. The adjustment is the ratio of total admissions to total UB records. This results in a total adjusted measure of resource use. The hospitals shall make reasonable efforts to correct data unacceptable to the Division or Department of Health.

	Center	Measure of Resource Use	Calculation of Inpatients
	ROUTINE SERVICES		
MSA &	Medical–Surgical Acute Care Units	Patient Days	Total LOS less ICU, CCU, NBN and OBS LOS ACU
PED &	Pediatrics		
PSA &	Psychiatric Acute Care Units		
PSY &	Psychiatric/Psychological Services		
OBS	Obstetrics		
BCU	Burn Care Unit		BCU LOS
ICU & CCU	Intensive Care Unit Coronary Care Unit	Patient Days	ICU + CCU LOS
NNI	Neonatal Intensive Care Unit	NNI Patient Days	Total ICU LOS for Newborn DRGs
NBN	Newborn Nursery	NBN Patient Days	Total LOS for Newborn DRGs less ICU LOS
	AMBULATORY SERVICES		
EMR	Emergency Service	EMR Charges (Inpatient EMR	EMR Admissions Revenue EMR Admissions)
CLN	Clinics	CLN Charges	None
HHA	Home Health Agency	OHS Charges	None
	ANCILLARY SERVICES		
ANS	Anesthesiology	ANS Charges	Direct
CCA	Cardiac Catheterization	CCA Charges	Direct
DEL	Delivery and Labor Room	DEL Charges	Direct
DIA	Dialysis	DIA Charges	Direct
DRU	Drugs Sold to Patients	PHM Charges (DRU)	Direct
EKG	Electrocardiology and Diagnostic	EDG Charges	Direct
NEU	Neurology		
LAB	Laboratory	BBK Charges and LAB Charges	Direct
MSS	Medical–Surgical Supplies Sold to Patients	CSS Charges (MSS)	Direct
NMD	Nuclear Medicine	NMD Charges	Direct
OCC	Occupational and Recreational	OPM Charges	Direct
SPA	Therapy and Speech Pathology and Audiology		
ORG	Organ Acquisition and	ORR Charges	Direct
ORR	Operating and Recovery Rooms		
PHT	Physical Therapy	PHT Charges	Direct
RAD	Diagnostic Radiology	RAD Charges	Direct
RSP	Respiratory Therapy	RSP Charges	Direct
THR	Therapeutic Radiology	THR Charges	Direct

(c) Cost per case allocation:

1. The Direct Patient Care Costs of each center (after the allocation of patient care general services in N.J.A.C. 10:52–5.11 and 5.12) are separated between inpatient, outpatient, and Skilled Nursing Facility (SNF) costs. Outpatient and SNF costs are excluded from the inpatient rates based on gross revenue reported to the Division. The total inpatient costs from each cost center are then divided by the hospital's corresponding total adjusted measure of resource use. This calculation produces ratios, including cost per patient day, cost per EMR admission, or a cost ratio per ancillary or therapeutic charge for each cost center. Each ratio is then multiplied by the corresponding cost center's measure of resource use of each DRG to calculate a cost per case for the hospital's case mix.

i. Patient days will be employed as the Measures of Resource Use to allocate MSA, PED, PSA, and OBS nursing costs. While patient days are used, the MSA, PED, PSA, OBS centers will be combined into ACU and ICU, and CCU will be combined into ICU. All other routine centers will remain as above.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

10:52–5.13 Reasonable cost of services related to patient care

(a) The Reasonable Cost of Services related to Patient Care includes:

1. Current non-physician direct patient care costs per case as adjusted by standard costs per case for Medicaid inpatients;

2. Current physician patient service costs, as modified for physician compensation arrangements pursuant to N.J.A.C. 10:52–5.12;

3. Indirect cost pursuant to N.J.A.C. 10:52–5.11 and 5.16;

4. Less a reduction for income not related to patient care, from those sources specified in N.J.A.C. 10:52–6.27 through 6.33 except all items reported as expense recovery to the Division, shall be so treated; and

5. Current major moveable equipment amount pursuant to N.J.A.C. 10:52–6.9.

(b) The Reasonable Cost of Services Related to Medicaid Patient Care will be adjusted by the application of economic factors pursuant to N.J.A.C. 10:52–5.17.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

10:52–5.14 Standard costs per case

(a) The standard to be used in the calculation of the proposed rate for each inpatient DRG is as follows:

1. For services provided prior to October 1, 1996, the standard to be used in the calculation of the proposed rates for each inpatient DRG is determined as the median plus five percent non-physician patient care costs per Medicaid case in all hospitals whose costs are included in the date base, and adjusted for labor market differentials and amount and type of Graduate Medical Education. Standards shall be calculated across all hospitals for which current cost bases were derived from a common reporting period.

2. For services provided on or after October 1, 1996, the standard to be used in the calculation of the proposed rates for each inpatient DRG is determined as the median non-physician patient care costs per Medicaid case in all hospitals whose costs are included in the data base and adjusted for labor market differentials. Standards shall be calculated across all hospitals for which current cost bases were derived from a common reporting period.

(b) The following is applicable for the determination of teaching costs for services provided prior to October 1, 1996 and for the criteria that shall be followed:

1. All residents initially employed as first-year residents (PGY1) by hospitals on July 1, 1987 or later must meet either criteria in (b)1i and ii, or (b)1i and iii listed below, in order to be included among those residents on which payment is based. To be similarly included, second-year residents (PGY2) must meet these same minimum requirements by July 1, 1988; third-year residents (PGY3), by July 1, 1989; fourth-year residents (PGY4), by July 1, 1990; fifth-year residents (PGY5), by July 1, 1991; and all residents by July 1, 1992.

i. Meet all the minimum criteria established by the New Jersey State Board of Medical Examiners required for a New Jersey medical license, with the exceptions of specific requirements for graduate medical education and that, if necessary, foreign medical graduates will be allowed to take the National Boards at the end of their first postgraduate year. The National Boards must be passed before the beginning of PGY3 in order to be counted in such graduates' PGY3.

ii. Graduation from a medical, dental or osteopathic school accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) or in the case of dental residents, the American Dental Association (ADA) or in the case of podiatric residents, the Council on Podiatric Medical Education (CPME).

iii. Graduation from a foreign medical school and passage of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) within three attempts. For residents beginning PGY1 in the State of New Jersey in July 1987 only, an Educational Commission for Foreign Medical Graduates (ECFMG) certificate may be substituted for FMGEMS, and passage of FMGEMS, mandatory before January 1, 1989, shall not be limited to three attempts.

2. For all graduate medical education programs which are subject to accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or, in the case of dental residents, the American Dental Association (ADA), or, in the case of podiatric residents, the Council on Podiatric Medical Education (CPME), accreditation must be maintained for residents in these programs to be used in determining the hospital's payment. Residents in unaccredited programs shall not be recognized in the teaching methodology for determining direct and indirect patient care costs.

3. The transfer of residents and associated costs between hospitals is permitted under the following conditions:

i. The number of positions transferred does not exceed the number relinquished;

ii. Both parties to the transfer must submit a letter of agreement to the Department of Health; and

iii. The Advisory Graduate Medical Education Council of New Jersey (AGMEC) must have recommended the transfer as being consistent with maintenance or improvement of program quality.

4. The approved costs associated with a transferred resident position shall not increase solely as a result of the transfer.

5. Beginning in rate year 1992, the changes in number of residents and associated costs due to transfers shall be reflected in each hospital's rates for the following rate year if the Division is so advised on or before April 15.

(c) For services provided prior to October 1, 1996, the methodology for determining hospital-specific patient care rate adjustments for graduate medical education (GME) shall be as follows:

1. In order to be eligible for GME reimbursement, hospitals must submit each year, before the issuance of rates, documentation that attests to current accreditation for all programs for which accrediting bodies exist.

2. For all programs which have maintained the appropriate accreditation, and have a minimum number of residents equal to the years in that program necessary for it to receive accreditation, direct and indirect patient care costs associated with Graduate Medical Education plus the hospital current costs must be calculated for each patient DRG as follows:

i. All DRGs shall be assigned to one of four mutually-exclusive residency categories: Medicine, Surgery, Pediatrics and OB/GYN. Assignment will be determined by the specialty of the resident who would, in most New Jersey teaching hospitals, have principal responsibility for care of a patient in a given DRG.

ii. Regarding medicine, the following shall apply:

(1) For teaching reimbursement purposes, a medical teaching hospital is defined as having an accredited program, with at least one Full Time Equivalent (F.T.E.) resident per year of the program, in Internal Medicine; Transitional/Flexible First Year; a medical specialty/subspecialty; and/or Radiology.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.I.

iii. Regarding surgery, the following shall apply:

(1) For teaching reimbursement, a surgical teaching hospital is defined as having an accredited program, with at least one F.T.E. resident per year of the program, in General Surgery; surgical specialty or subspecialty Anesthesiology; and/or Pathology.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.II, incorporated herein by reference.

iv. Regarding Obstetrics/Gynecology, the following shall apply:

(1) For teaching reimbursement, an Obstetrics/Gynecology teaching hospital is defined as having an Obstetrics/Gynecology program with at least one F.T.E. resident per year of the program.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.III, incorporated herein by reference.

v. Regarding pediatrics, the following shall apply:

(1) For teaching reimbursement, a pediatric teaching hospital is defined as having an accredited pediatric program, with at least one F.T.E. resident per year of the program.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.IV, incorporated herein by reference.

vi. Regarding Family Practice, the following shall apply:

(1) For teaching reimbursement, a Family Practice hospital is defined as having an accredited Family Practice Teaching Program and shall not be considered in neutralizing costs for standard setting.

(2) For payment purposes, a Family Practice supplement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI vii, incorporated herein by reference. A teaching adjustment factor shall be applied in calculating the rates for hospitals experiencing changes in accreditation status or changes in number of residents since the base year, and to reflect any differences between actual and cap resident counts.

(3) Direct and indirect costs, including resident salaries and other educationally related costs, shall be recognized in rates in accordance with the GME reimbursement methodology which neutralizes the costs of teaching within medical, surgical, OB/GYN and pediatric DRG categories and deneutralizes these costs for setting payment rates.

(4) For purposes of payment, all deneutralization factors shall be considered to be equal to one or greater.

(d) Determination of the labor equalization factor to calculate Statewide standard costs per case shall be as follows:

1. An equalization factor shall be calculated for the non-physician direct patient care costs of each hospital (excluding ambulatory care centers) to account for differing hospital pay scales in the calculation of standards. Each hospital's equalization factor is determined as non-physician direct patient care costs (prior to allocation of costs from patient care general services) at average pay scales for all New Jersey hospitals (excluding those hospitals classified as Rehabilitation Facilities) divided by Labor Market Area non-physician direct patient care costs.

2. The Labor Market Areas recognized in 1990 rate setting at N.J.A.C. 8:31B–3.22(d)3 will be used for rate setting in subsequent years.

3. Labor Market Areas are:

		Counties or Municipalities
i.	Paterson—Clifton—Passaic	Passaic
ii.	Hackensack	Bergen
iii.	Newton—Phillipsburg	Sussex, Warren
iv.	Trenton—Flemington	Mercer, Hunterdon
v.	Newark, Suburban	Union, Essex, Somerset, Morris, except cities of Elizabeth, Belleville, East Orange, Irvington and Newark
vi.	Jersey City	Hudson
vii.	New Brunswick—Perth Amboy	Middlesex
viii.	Long Branch—Toms River	Monmouth, Ocean
ix.	Atlantic City—Cape May	Atlantic, Cape May
x.	Vineland—Millville Camden—Salem	Burlington, Gloucester Cumberland
xi.	Newark, Central City (not included in v. above)	Newark, Elizabeth, Belleville, East Orange, Orange, and Irvington

4. This factor is multiplied by the hospital's actual cost per case for all DRGs.

5. Labor costs shall be adjusted to Statewide averages by first grouping all non-physician direct patient care labor costs (after fringe benefit costs have been distributed) into eight labor categories as follows:

i. Registered Nursing: Includes non-physician salaries reported in RNS, CCA, DEL, DIA and ORR cost centers.

ii. Licensed Practical Nursing: Includes non-physician salaries reported in LPN cost center.

iii. Attendants: Includes non-physician salaries reported in ATT and CSS cost centers.

iv. Clerical: Includes non-physician salaries reported in CLR cost center.

v. Health Technical: Includes non-physician salaries reported in BBK, EDG, LAB, RAD, NMD, and THR cost centers.

vi. Therapists/Technical: Includes non-physician salaries reported in OPM, PHM, PHT, and RSP cost centers.

vii. General Services: Includes non-physician salaries reported in DTY, HKP, PLT, and L&L cost centers.

viii. Administrative and Clerical: Includes non-physician salaries reported in the MRD, A&G, FIS, EDR, and PCC cost centers.

6. The portion of the routine cost centers that shall be attributed to each of the four types of nursing skill levels is based on the distribution of costs as reported to the Division.

7. By dividing non-physician direct patient care costs by the non-physician hours in each category, the average hourly rates for the eight labor categories are computed for each hospital. The sum of all of the hospital's non-physician direct patient care costs for the eight labor categories divided by the total non-physician hours is equal to the Statewide average. To determine each hospital's labor equalization factor, the Statewide average cost per hour for each labor category is multiplied by the hospital's number of non-physician labor hours for that category and is added to all other non-physician costs (that is, supplies and other costs). This amount is divided by the result of the same calculation using the Labor Market Area cost per hour, rather than Statewide average, resulting in the hospital's equalization factor.

8. Whenever the number of hospitals in a given labor market area decreases to a number less than four, the Division shall calculate and compare the mean equalization factors of the Labor Market Area, both before and after the decrease. If they differ by plus or minus one percent or more, that Labor Market Area shall be merged with the geographically contiguous Labor Market Area having the most similar hourly wage rate, averaged for all salaried employees and based on the most recent data available; the factors of all Labor Market Areas shall be recalculated and effective in the following rate year.

(e) Calculation of standards shall be as follows:

1. Effective for services provided prior to October 1, 1996, the calculation of standards shall be based on all hospital UB records for Medicaid patients, where Medicaid is primary payor. The cost per case of each hospital's Medicaid patients with UB records categorized by inpatient DRGs is multiplied by each hospital's equalization factor and, for the appropriate DRGs and hospitals, reduced by a rate expressing the amount and type of graduate medical education for the hospitals pertaining to each DRG. The median plus five percent equalized cost of all such records in all hospitals calculating after teaching costs have been removed from the hospitals' preliminary cost bases is the incentive standard for each DRG.

2. Effective for services provided on or after October 1, 1996, the calculation of standards shall be based on all hospital UB records for Medicaid patients, where Medicaid is the primary payor. The cost per case of each hospital's Medicaid patients with UB records categorized by inpatient DRGs is multiplied by each hospitals' equalization factor for the appropriate DRGs and hospitals. The median equalized cost of all such records in all hospitals calculated after teaching costs have been removed from the hospitals' preliminary cost bases is the incentive standard for each DRG.

3. Determination of Labor Unequalization Factor to Calculate Standard Cost Per Case of Each Labor Market Area.

i. An unequalization factor shall be calculated for the non-physician direct patient care costs of each hospital to account for differing prevailing compensation patterns across New Jersey's Labor Market Areas in the comparison of hospital and standard costs per case. The Statewide standard times the unequalization factor is the unequalized standard in terms of the hospital's Labor Market Area.

ii. The reciprocal of the hospital's equalization factor is the hospital's unequalization factor and is applied to non-physician costs only.

(f) Effective for services provided on or after October 1, 1996, GME and IME shall no longer be reimbursed through the Medicaid hospital inpatient DRG rates. After all indirect costs have been fully allocated to the using cost centers, GME and IME costs shall be removed from the cost base before calculating the standards and Medicaid hospital inpatient rates. GME and IME shall be reimbursed in accordance with N.J.A.C. 10:52–12.

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).
Substantially amended section.

Law Review and Journal Commentaries

Hospitals. Steven P. Bann, 138 N.J.L.J. No. 9, 52 (1994).

Case Notes

Burden was on hospitals to show that regulations governing hospital rates for Medicaid patients were invalid. Matter of Adoption of N.J.A.C. 10:52–5.14(d) 2 and 3, 276 N.J.Super. 568, 648 A.2d 509 (A.D.1994), certification denied 142 N.J. 448, 663 A.2d 1355.

Division of Medical Assistance and Health Services, was not obligated to use components of Medicare rate methodology with respect to Medicaid program. Matter of Adoption of N.J.A.C. 10:52–5.14(d) 2 and 3, 276 N.J.Super. 568, 648 A.2d 509 (A.D.1994), certification denied 142 N.J. 448, 663 A.2d 1355.

Regulations governing hospital rates for Medicaid patients were valid. Matter of Adoption of N.J.A.C. 10:52–5.14(d) 2 and 3, 276 N.J.Super. 568, 648 A.2d 509 (A.D.1994), certification denied 142 N.J. 448, 663 A.2d 1355.

10:52–5.15 Reasonable direct cost per case

(a) Inpatient direct cost per case shall be determined as follows:

1. The reasonable direct cost per Medicaid case for those hospitals receiving rates in accordance with this subchapter for every DRG shall include incentives and disincentives, as appropriate, which shall be termed the boundaries of payment and are calculated as follows:

i. Effective for services provided prior to October 1, 1996, the incentive standard is multiplied by the unequalization factor, the physician mark-up, the deneutralization factor, and Residents adjustment factor.

ii. Effective for services provided on or after October 1, 1996, the incentive standard is multiplied by the unequalization factor and the physician mark-up.

(b) Inpatient outliers: The costs of low length of stay outliers shall be divided by the low length of stay days to arrive at a low per diem. The costs of high length of stay outliers shall be divided between both high outlier cost and the inlier rate. The high outlier cost net of the inlier rate times the high outlier cases shall be divided by the acute days of the patient's total stay (admission to discharge) to arrive at a high outlier per diem. High outlier cases shall be reimbursed the inlier rate plus the high per diem multiplied by the acute days of the stay.

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)1i, inserted text "Effective for services provided prior to October 1, 1996"; and added (a)1ii.

10:52–5.16 Net income from other sources

(a) The net gain (loss) from Other Operating and Non–Operating Revenues (as defined in N.J.A.C. 10:52–6.27 through 6.34) and expenses of the reporting period which are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 10:52–6.27 through 6.34) as reported to the Division is subtracted from (added to) indirect costs of the Preliminary Costs Base.

(b) Such revenue shall include all Other Operating and Non–Operating Revenues and Expenses reported per Standard Hospital Accounting and Rate Evaluation (SHARE) cost center costs and "expense recoveries" as Case B and all other items reported as to their case specified in N.J.A.C. 10:52–6.27 through 6.34.

10:52–5.17 Update factors

(a) The economic factor is the measure of the change in prices of goods and services used by New Jersey hospitals. The economic factor will be the factor recognized under the TEFRA target limitations.

(b) The technology factor takes into account the costs of adopting quality enhancing technologies.

1. The hospital-specific economic factor is the weighted average of the recorded and projected change in the value of its components. The weight given to each component is its share of that hospital's total expenditure. The projection of individual components shall be based, where appropriate, on legal or regulatory changes which fix the future value of a proxy. Components which are of particular importance may be projected through the use of time series analysis on other relevant indicators.

(c) Base-year direct patient care and indirect rates shall be multiplied in succeeding years by a technology factor to provide prospective funds to support hospital adoption of quality-enhancing technologies. The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost-increasing technologies, and ProPAC's allowance for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC.

(d) In addition, the following payment rates will be in effect for these special procedures:

1. Liver Transplants: payment for DRG 480 will be $72,139 in 1988 dollars.

2. Heart Transplants: payment for DRG 103 will be $72,438 in 1988 dollars.

3. Cochlear Implants: payment for DRG 759 will be $21,608 in 1988 dollars.

4. Bone Marrow Transplants: payment for DRG 481 will be $46,599 in 1988 dollars.

5. Neonate rates: payment for neonatal DRGs as defined by New Jersey Grouper 8.0 will be based on 1989 actual New Jersey patient volume.

(e) For determination of the payment rates, direct patient care is increased for the following components:

1. Indirect patient care for items other than listed in N.J.A.C. 10:52–5.11;

2. Health Planning fees;

3. Capital facilities allowance;

4. Physician fee for service;

5. Child psychiatric hospital direct and indirect;

6. Resident count correction (only for services provided prior to October 1, 1996).

7. Special perinatal expense adjustment;

8. Trauma center adjustment;

9. GME reversal (only for services provided prior to October 1, 1996);

10. Hemophilia adjustment;

11. Regional perinatal adjustment;

12. Personnel health allowance;

13. Pediatric rate adjustment;

14. Sickle cell adjustment;

15. Continuous adjustments;

16. Outlier reversal adjustment; and

17. Poison Control Costs.

(f) No Statewide transition adjustment not otherwise specified in this chapter will be included in the rate.

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)6 and (a)9, added text "(only for services provided prior to October 1, 1996)".

10:52–5.18 Capital facilities

(a) Capital Facilities, as defined in N.J.A.C. 10:52–6.18, shall be included in the rate in the following manner:

1. Building and fixed equipment:

i. The yearly Capital Facilities Allowance is computed using information provided by the Share Cost Reports. For hospitals on a calendar year basis, this amount will be its 1992 depreciation and interest expense, excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery. For those hospitals on a fiscal year basis, actual year's depreciation and interest applicable to rate year 1992 shall be used excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery.

ii. Effective for services provided on or after October 1, 1996, all building and fixed depreciation and interest capital costs as defined in N.J.A.C. 10:52–6.18 related to GME programs shall be determined based on the 1992 audited Medicare Cost Report (HCFA–2552) and shall be excluded from the base year cost used to calculate the Medicaid DRG inpatient rates.

2. Major Moveable Equipment: For the purpose of calculating the Price Level Depreciation Allowance, Major Moveable Equipment is grouped into four categories based on the cost center function where the equipment is utilized: Beds and nursing equipment; Diagnostic and therapeutic equipment; General service equipment; and Business service equipment.

i. The following rules shall apply in calculating the Price Level Allowance for a given year:

(1) Only equipment which has not been fully depreciated at the start of the fiscal year is to be used in the calculation of the Price Level Allowance.

(2) The depreciation recorded and reported on all equipment subject to the Price Level Allowance must be calculated by the straight-line method, using at the time of the cost filing the most recent approved American Hospital Association (AHA) Recommended Useful Life (that is, 1978 revision) or Asset Depreciation Range (ADR).

(3) Only capitalized equipment and related capitalized costs can be used in the calculation of the Price Level Allowance.

(4) The price level factors for each of the four categories will be developed by the Division. For years prior to current cost base year, the factors to be used for price leveling depreciation are as follows:

Category	Proxy
Beds and Nursing Equipment	Marshall and Swift Hospital Equipment Cost Index
Diagnostic and Therapeutic Equipment	Marshall and Swift Hospital Equipment Cost Index
General Service Equipment	Producer Price Index (PPI) 1161, Food Products Machinery (41.18%), PPI 1241.02, Laundry Equipment (23.53%). PPI 113 less 1134 and 1136, Metalworking Machinery less Industrial Furnaces and Abrasive Products (35.29%).
Business Service Equipment	PPI 1193 less 1193.06, Business and Store equipment (less Coin Operated Vending Machines) and PPI 122, Commercial Furniture.

(5) Assets retired before the close of the fiscal year are not to be used in the calculation of the Price Level Allowance.

(6) The amount of the Price Level Allowance shall be calculated as follows:

(A) Current year straight-line depreciation of each asset being depreciated is multiplied by the price level factor corresponding to the year the asset was acquired to determine price level depreciation. Straight-line depreciation is then subtracted from price level depreciation and the result totaled to determine the amount of the Price Level Allowance provided by the following calculation: Algebraically the calculation is as follows:

D . . . (equals) Current year depreciation, ordered by the year of acquisition of the asset being depreciated.
F . . . (equals) Price level factor for the year the asset was acquired.
PLA . . . (equals) Price Level Allowance.
PLA . . . (equals) (D × F) - D.

(7) The interest component of cash disbursements relative to capitalized Major Moveable Equipment leases is to be classified as interest expense, in accordance with GAAP, and not used as a basis for calculating the price level depreciation premium.

(8) The total Price Level Allowance will be allocated to cost centers based upon the accumulated depreciation of all Major Moveable Equipment not fully depreciated.

(b) Any new capital facilities construction with a valid certificate of need from the New Jersey Department of Health and Senior Services may request a capital facilities adjustment in rates through the review and appeal process as described in N.J.A.C. 10:52–9 except that a hospital which meets the requirements of (b)1 below may request a capital facilities adjustment in accordance with (b)2 below.

1. A hospital may submit an appeal specific to its CFA without going through the full rate review process, if:

i. The appeal is for a single capital project in excess of $20 million which is for replacement beds which reduce the number of hospital beds available in the State and as of September 15, 1997, the hospital has an approved certificate of need for this project;

ii. The hospital receives no direct State appropriation; and

iii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low income revenue percentage shall be based on the sum of the Medicaid revenue as reported on Forms E–5 and E–6, line 1, column E, plus the Charity Care revenue as reported on Forms E–5 and E–6, line 1, column J, divided by the sum of the total revenue as reported on Forms E–5 and E–6, line 1, column M.

2. If all of the conditions in (b)1 above are met, the hospital shall submit all supporting documentation to the Department of Human Services, Division of Medical Assistance and Health Services, Administrative and Financial Services, PO Box 712, Mail Code #42, Trenton, New Jersey 08625–0712. The Division shall issue a written determination once the supporting documentation is reviewed and the hospital may appeal the determination pursuant to N.J.A.C. 10:52–9.1(d).

3. In addition to an adjustment to its rates, a hospital which meets the condition of (b)1 above shall receive an additional payment for its Capital Project Funding related to its Medicaid and NJ KidCare-Plan A managed care utilization.

i. Payments to eligible hospitals shall begin the calendar year following project completion and facility operation. These hospitals shall receive a lump sum payment for Capital Project Funding each month. The monthly payment shall be one-twelfth of the approved annual amount.

ii. The hospital-specific Capital Project Funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid and NJ KidCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

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).
Deleted (a)1i, relating to capital cash requirements; recodified former (a)1ii as (a)1i and deleted subparagraph 1 of that paragraph; and inserted new (a)1ii.
Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).
In (b), added the exception; and added (b)1 and (b)2.
Amended by R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).
Added (b)3.

10:52–5.19 Division adjustments and approvals

(a) Any modifications including any statutory or regulatory changes or changes in patient care physician compensation arrangements shall be classified as direct or indirect, and as to the financial elements affected and each element adjusted proportionately.

(b) The Division shall also approve adjustments to hospitals' Schedules of Rates for 1993 and subsequent years as necessary to subtract approved costs associated with residents not meeting the minimum requirements as defined in N.J.A.C. 10:52–5.14(b); for any costs associated with residents in programs which have lost accreditation as defined in N.J.A.C. 10:52–5.14(b); and for any costs associated with previously approved but now vacant residency positions which are unfilled as a result of a hospital's inability to recruit residents meeting these minimum standards. These costs shall include, but are not limited to, resident salaries and fringes, faculty salaries, malpractice and supplies.

(c) The Division may approve hospital appeals to transfer Division approved resident positions and associated costs between hospitals. A hospital may appeal under any option to reduce or increase the number of resident positions by transfer. An addition of resident positions by transfer may not result in a change to a higher teaching status peer group. A reduction of resident positions by transfer may result in a change to a lower teacher status peer group. The approved costs associated with a transferred resident position may not increase solely as a result of the transfer.

(d) The Division shall decide to which hospitals the approved resident positions and associated costs may be transferred.

(e) Subsections (a) through (d) above apply for dates of services provided prior to October 1, 1996. Effective for services provided on or after October 1, 1996, this section is no longer applicable.

Amended by R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).
Added (e).

10:52–5.20 Derivation from Preliminary Cost Base

(a) Apportionment of Financial Elements based on direct costs shall be as follows:

1. All other Financial Elements are added to direct Medicaid patient care costs as percentages of direct costs per Medicaid case. The Schedule of Rates is set such that all Medicaid patients' rates are based on the cost of services received by Medicaid recipients, including a proportionate share of indirect financial elements requirements of operating hospital facilities.

2. In the event that a hospital is self-insured for employee health benefits, the percentage of personnel health allowance recognized in the rates shall be proportioned to the number of Medicaid recipients serviced by the facility to financial elements from payers for such costs.

3. Each hospital shall receive from the Division a base rate order detailing the Schedule of Rates.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

10:52–5.21 Schedule of rates—effective date

All rates pursuant to this subchapter, as approved or modified, shall be effective as of October 1, 1996, of the rate year and then January 1 for subsequent rate years except for fiscal year hospitals whose rates shall be effective as of the first day of the "fiscal" rate year.

Amended by R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).
Amended effective date.

SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

10:52–6.1 Reporting period

(a) The basic reporting period is the 12 consecutive calendar months utilized for Medicare reporting in the year prior to the hospital's first Medicaid rate.

(b) New hospitals beginning operations on any day other than January 1 must select an initial reporting period beginning on the first day of operation, through the last month preceding the hospital's fiscal year.

(c) Each calendar year's Financial Elements Reporting Forms are due on May 31 of the following year. Each year's Audited Financial Statement is due on May 31 of the following year.

10:52–6.2 Objective evidence

(a) Information produced by the accounting process should be based, to the extent possible, upon objectively determined facts. Transactions should be supported by properly executed documents such as charge slips, purchase orders, suppliers' invoices, cancelled checks, etc. Such documents serve as objective evidence of transactions and should be retained as a source of verification of the data in the accounting records.

(b) Certain determinations that enter into accounting records are based on estimates. Such estimates should be based on past experience modified by expected future considerations. Items of Other Operating Expenses, if not directly classified by the hospital, if large in amount, must be identified through a cost study, and if small in amount, costs may be deemed equal to revenue and such costs apportioned among the appropriate natural classifications of expense based on the hospital's estimate or the classifications of the center where the costs originated. Worksheets are provided along with Reporting Schedules to aid the hospital in making all appropriate reclassifications. All such reclassifications should be consistent with the concept of materiality, as defined in N.J.A.C. 10:52–6.5.

(c) Books, papers, records, or other data relevant to matters of hospital ownership, organization, and operation must be maintained. The data must be maintained in an ongoing recordkeeping system which allows the data to be readily verified by qualified auditors.

10:52–6.3 Consistency

(a) Consistency refers to continued uniformity during a period and from one period to another in methods of accounting, mainly in valuation bases and methods of accrual, as reflected in the financial statements of an accounting entity. Consistency is very important to the development and analysis of trends on a year to year basis and as a means of forecasting. However, consistency does not require continued adherence to a suboptimal method or procedure. Any change of accounting procedure, consistent with the materiality principle, must be brought to the attention of the Division by way of a cover letter which will accompany the hospital's Financial Elements Report to include both a description and analysis of reporting impact of such accounting procedure changes.

1. As an example, the accounting principle of accrual reporting may cause some hospitals who currently account for vacation on a cash basis to incur a one time reporting of expenses related to vacation time earned by employees but not yet taken. Such one time costs must be included in a cover letter and the Financial Elements Report shall identify only those vacations costs accrued in the current reporting period.

(b) Any accounting and reporting changes due to subsequent revisions of this plan or the documents referred to herein shall be reported in accordance with the instructions which accompany those revisions.

10:52–6.4 Full disclosure

The concept of full disclosure requires that all significant data be clearly and completely reflected in accounting reports. For example, if a hospital were to change its method of accounting for certain transactions, and if the change was a material effect on the reported financial position the nature of the change in method and its effect must be disclosed when reporting costs. No fact that would influence the decisions of management, the governing board, or other users of financial statements shall be omitted from or concealed in accounting reports.

10:52–6.5 Materiality

An amount is material if its exclusion from the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements.

10:52–6.6 Basis of valuation

(a) Historical cost is the basis used in accounting for the valuation of all assets and in recording all expenses (except fair market value in the case of donated non-cash goods and services). Historical cost, simply defined, is the amount of cash or cash equivalents given in exchange for properties or services at the time of acquisition. It is the basis for the valuation of assets and for the recording of most expenses. Cost ordinarily has been the basis of accounting for assets and expenses because it is a permanent and objective measurement that reflects the accountability of management for the utilization of hospital funds.

(b) Although the basis for developing capital-related financial elements shall be Division approved replacement costs of plant and equipment, where appropriate, hospitals shall be required to maintain records and report assets and related depreciation according to both historical values and price leveled values as prescribed in this plan.

(c) Long-term investments shall be reported at current market value as with corresponding income or loss reported as realized or unrealized.

(d) Hospitals frequently acquire property, equipment, services and supplies by donation. The property, equipment, service and/or supply shall be considered donated when acquired without the hospital's making any payment for it in the form of cash, property or service. The property, equipment, service or supply shall be valued at acquisition at the fair market value which is the price that the asset would cost by bona fide bargaining between well-informed buyers and sellers at the date of donation (regardless of the date of receipt). The fair market value of donated services must be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations may be evidenced by a contractual relationship which may provide the basis for valuation. The amounts recorded shall not exceed those paid others for similar work.

(e) The value of donated goods or services of a type not consistent with the definition given shall not be included as operating expenses (for example, donated services of individuals, such as volunteers, students and trustees).

10:52–6.7 Accrual accounting

In order to provide the necessary completeness, accuracy and meaningfulness in reporting data, the accrual basis of accounting is required. Accrual accounting is the recognizing and recording of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time periods in which they apply rather than when cash is received or paid.

10:52–6.8 Accounting for minor moveable equipment

(a) Minor moveable equipment includes such items as waste baskets, bed pans, silverware, mops, buckets, etc. The general characteristics of this equipment are:

1. In general, no fixed location and subject to use by various departments within a hospital;

2. Comparatively small in size and unit cost; and

3. Generally, a useful life of less than three years.

(b) There are three ways in which the cost of minor moveable equipment may be recorded:

1. The original cost of this equipment may be capitalized and not depreciated. Any replacements of or additions to this base stock would be charged to operating expense.

2. The original investment in this equipment may be capitalized and written off over three years. All subsequent purchases shall be written off over three years.

3. All purchases of minor equipment may be capitalized and depreciated over their estimated useful lives.

(c) Once a hospital has elected one of these methods, that method must be used consistently thereafter.

10:52–6.9 Accounting for capital facilities costs

(a) Capital Facilities costs include owned or leased land, land improvements, buildings, fixed equipment, leasehold improvements, major moveable equipment and related debt service requirements.

(b) Land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the hospital).

(c) Buildings include the basic walled structure or shell of a hospital and additions thereto.

(d) Fixed Equipment and Building Components include roofs and attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

1. Affixed to the building and not subject to transfer of movement;

2. Used for general purpose rather than for specific department functions.

(e) Leasehold improvements include betterments and additions made by the tenant to the lease property. Such improvements become the property of the lessor after the expiration of the lease.

(f) Major moveable equipment is that equipment which usually is in a relatively fixed location in the building, but is capable of being moved, generally has a specific function related to cost center functions, and has a life expectancy of at least three years.

(g) Debt service requirements are principal and interest on buildings, fixed equipment, land, land improvements, leasehold improvements, and capitalized renovations as well as escrow payments, in addition to principal and interest required under the terms of a mortgage, but not including operating expenses as defined by GAAP and lease payments required for leased assets capitalized in accordance with the GAAP.

1. Classification of Fixed Asset Expenditures shall be as follows:

i. Assets and related liabilities, as defined above, must be recorded in Unrestricted Funds, since segregation in a separate fund would imply the existence of restrictions on the use of the asset. This includes the costs of construction in progress.

2. Basis of Valuation shall be as follows:

i. Property, Plant, and Equipment, whether owned or leased, must be reported on the basis of cost. Cost shall be defined as historical cost or fair market value at the date of bequest in the case of donated property.

ii. Interest and capitalization on site preparation costs associated with borrowings for, or purchase of, major moveable equipment shall be included with the cost of the equipment.

3. Accounting Control shall be as follows:

i. To maintain accounting control over capital assets of the hospital, a plant asset ledger should be maintained as part of a hospital's general accounting records. Some items of equipment shall be treated as individual units within the plant ledger when their individuality and unit cost justify such treatment. Other items of equipment, if they are similar and are used in a single cost center, may be grouped together and treated in a single unit within the ledger so long as such items are depreciated in a manner equivalent in result to individually depreciating each item.

4. Capitalization Policy shall be as follows:

i. If an asset has, at the time of its acquisition, an estimated useful life of greater than three years and a historical cost in excess of $300.00, its cost must be capitalized.

ii. If an asset does not meet the above criteria, its cost must be recorded as an expense in the year it is acquired. Alterations and renovations which are in excess of $300.00 and which extend the life of the asset renovated a minimum of three years must be capitalized. Alterations and renovations that do not meet the above criteria shall be reported as operating expense under repair and maintenance costs in the current period.

iii. The following shall be the required Capitalization Policy for the reporting assets acquired and renovations per (g)6 below, subsequent to a hospital's Medicaid Schedule of Rates. Assets acquired prior to this date shall be reported in accordance with GAAP.

5. Frequently, hospitals borrow funds to construct new facilities or modernize and expand existing facilities. Interest costs incurred during the period of construction must be capitalized as part of the cost of the construction for reporting purposes. The period of construction is considered to extend to the date the constructed asset is put into use. When proceeds from a construction loan are invested and income is derived from such investments during the construction period, the amount of interest expense to be capitalized must be reduced by the amount of such income.

6. Depreciation Policies shall be as follows:

i. Depreciation allowances generated from assets used in the hospital's operations are to be reported as an operating expense in the unrestricted funds. Straight-line depreciation must be reported for all assets, with replacement cost provisions (subject to appropriate planning requirements) and debt service requirements for capital assets utilized for Services Related to Patient Care provided in N.J.A.C. 10:52–5.13.

ii. The estimated useful life of a depreciable asset is its normal operating or service life in terms of utility to the hospital. Some factors to be considered in determining useful life include normal wear and tear, obsolescence due to reasonably expected technological advances, climatic or local conditions and the hospital's policy of repair and replacement. Costs of alterations, renovations, etc. over $300.00 which extend the life of an asset at least three years shall be added on the remaining book value of the altered or renovated asset and depreciated straight-line over the remaining useful life of the asset.

iii. The preferred depreciation policy for reporting purposes is for hospitals to record one-half year depreciation in the first year an asset is acquired and one-half year depreciation in the last year of the asset's useful life, but that buildings or major renovations be depreciated based on the month first put into use. However, any depreciation policy consistent with GAAP is acceptable.

iv. When an asset is retired, the difference between its book value (historical acquisition cost plus capitalized renovations less accumulated depreciation) and its net salvage value shall be recorded as an adjustment to that year's depreciation expense in the cost center or classification to which the asset was assigned.

v. When Major Moveable Equipment has reached its useful life, but remains in use, its historical cost and accumulated depreciation may be retained in the accounting records by department. However, hospitals must be able to report fully depreciated assets separately from those which are not fully depreciated.

7. Debt Financing for Plant Replacement, Renovation and Expansion purposes shall be as follows:

i. Debt financing for capital facilities may take many forms. Under the terms of most debt financing agreements, the debtor shall be required to perform or is prohibited from performing certain acts. In many instances, debt financing gives rise to special accounting treatment because of discounts and premiums on bond issues, financing charges, formal restrictions on debt proceeds, and sinking and other required funds.

(1) Discounts and premiums arising from the issue of bonds shall be amortized over the life of the related issue(s).

(2) Costs of obtaining debt financing other than discounts (for example, legal fees, underwriting fees, special accounts costs) shall be reported as deferred costs and amortized over the life of the related debt.

(3) Debt agreements for financing plant replacement and expansion programs may or may not require formal segregation of debt proceeds prior to their use. Proceeds which are not required to be formally segregated prior to their use shall be reported as other noncurrent assets in the Unrestricted Fund.

8. Sinking and Other Required Funds shall be as follows:

i. These funds are usually established to comply with loan provisions whereby specific deposits shall be used to insure that adequate funds are available to meet future payments of:

(1) Interest and principal (retirement of indebtedness funds); or

(2) Property insurance, related taxes, repairs and maintenance costs, equipment replacement (escrow funds).

ii. Funds of this nature shall also be required to be held by trustees outside the hospital. Income generated from the investment of such funds may be immediately available to the hospital or such income may be held by the trustee for some future designated purpose.

iii. All internally generating sinking and other required funds shall be accounted for in the following manner:

(1) All fund assets, unless the hospital relinquishes control of the fund through a trustee arrangement, must be recorded in the Restricted Internally Generated Plant Replacement Fund as a long-term investment. Payments to a trustee for sinking fund purposes shall be recorded as reductions in the associated long-term debt.

(2) All income generated from the investment of such funds, except as excluded in (g)8i-iii above, must be recorded as non-operating revenue in this fund, except as required under, "Interest Expense during Period of Construction" (see N.J.A.C. 10:52–6.9). Income generated from funds under covenant agreement may be accounted for as an addition to the appropriate restricted fund balance account.

9. Early Debt Retirement shall be as follows:

i. Many bond contracts provide for the calling of any portion or all of the issue at the option of the issuer at a stated value usually above par, for the purpose of enabling the organization to reduce its indebtedness before maturity as occasion arises, or to take advantage of opportunities to borrow on more favorable terms. Bonds are often retired piecemeal through sinking fund operations.

ii. Costs incidental to the recall of bonds before their date of maturity are considered debt cancellation costs. Such costs include bond recall penalties, unamortized bond discounts and expenses, legal and accounting fees, etc. These costs must be reduced by any unamortized bond premiums and recorded in the Unrestricted Fund in accordance with GAAP.

10:52–6.10 Timing differences

Timing differences result when accounting policies and practices used in an organization's accounting differ from those used for reporting operations to governmental units collecting taxes or to outside agencies establishing or making payments based upon the reported operations. These differences shall be reported on the hospital's records when they arise in accordance with relevant American Institute of Certified Public Accountants (AICPA) policies.

10:52–6.11 Self-insurance

(a) Self-insurance by a hospital for potential losses due to unemployment, and worker's compensation claims, but excluding self-insurance for employee health care, to be provided by the hospital asserted or otherwise, places all or part of the risk of such losses on the hospital rather than passing all or part of such losses to a third party. Where this method of insuring is used by the hospital, the payments into the fund or pool (if one is maintained) or payments on actual losses incurred shall be considered as insurance expense.

(b) The method of self-insurance elected by a hospital, other than for those items listed in (a) above, must conform to the following:

1. The hospital or pool establishes a fund with a recognized independent fiduciary such as a bank or a trust company as a self-insurance fund. The hospital or pool and fiduciary enter into a written agreement which includes all of the following elements:

i. The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.

ii. The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control. Thus, the home office of a chain organization or a religious order of which the hospital is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the hospital or persons related to the hospital shall not be permitted.

iii. The agreement must provide that withdrawals must be for malpractice and comprehensive general patient liability losses only and those expenses listed in (d) below. Any rebates, dividends, etc. to the hospital from the fund shall be used to reduce allowable cost. Furthermore, evidence of a practice of payments from the fund for purposes unrelated to the proper administration of the fund may result in a withdrawal of recognition of the self-insurance fund. In such instances, payments into the fund shall not be considered an allowable cost.

iv. The agreement must require that a financial statement be forwarded to the hospital or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period. This statement must show the balance in the fund at the beginning of the period, current period contributions, and amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance. This report and fiduciary's records must be available for review and audit.

v. The agreement must provide that any income earned by the fund less any income taxes attributable to such income must become part of the fund and must be used in establishing adequate fund levels.

2. Soundness of the fund, as follows:

i. The hospital shall receive and retain an annual certified statement from an independent actuary, insurance company, or broker that has actuarial personnel experienced in the field of medical malpractice and general liability insurance. To be independent, there must not be any financial ownership or control, either directly or indirectly in the hospital.

ii. The actuary, insurance company, or broker shall determine the amount necessary to be paid into the fund. The fund should include reserves for losses based on accepted actuarial techniques customarily employed by the casualty insurance industry and expenses related to the self-insurance fund as specified in (b)4 below. The actuary, insurance company, or broker shall also provide for an estimate of the amounts to be in excess of what is reasonably needed to support anticipated disbursements from the fund.

iii. The actuary, insurance company, or broker must state the actuarial basis and the coverage period used in establishing reserve levels. Reserves shall not be recognized as allowable costs for losses specifically denied herein. Thus, reserve payments shall not be recognized for items such as:

(1) Losses in excess of the greater of 10 percent of a hospital's net worth or $100,000 where a hospital elects to pay losses directly in lieu of establishing a funded self-insurance fund;

(2) Losses in excess of coverage levels which do not reflect the decisions of prudent management; and

(3) Losses in excess of coverage for events that occurred prior to a hospital's participation under the Commission.

iv. The actuary, insurance company, or broker must provide its workpapers upon request.

3. A hospital or pool shall have an ongoing claims process and risk management program. The hospital or pool must demonstrate that it has an ongoing claims process to determine whether malpractice and comprehensive general patient liability exists, its cause, and the cost of claims. A hospital or pool may either utilize its qualified personnel or an independent contractor, such as an insurance company, to adjust claims. In addition, a hospital or pool must obtain adequate legal assistance in carrying out its claims process. Each hospital must also have an adequate risk management program to examine the cause of losses and to take action to reduce the frequency and severity of them. Such risk management program has the essential characteristics of programs required by insurers which currently insure providers for these risks. Therefore, a hospital must have an ongoing safety program and professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general patient liability incidents.

4. The following expenses shall be considered costs attributable to a self-insurance fund established by a hospital or pool: expenses of establishing the fund or pool; expenses for administering the claims management program; expenses involved with maintenance of the fund by the fiduciary; legal expenses; actuarial expenses; excess insurance coverage (if purchased by the fiduciary or pool); risk management (if performed by the fiduciary or pool), to the extent that such expenses are related to the hospital's self-insurance program. All other expenses shall not be considered costs attributable to the fund, but shall be included in provider administrative and general costs in the year incurred.

10:52–6.12 Related organizations

(a) Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. Such organizations are independent if they are so characterized by their own charter, by-laws, tax-exempt status and governing board or a sufficient combination of these characteristics to demonstrate their independent existence from the hospital. The financial reporting of these organizations shall be separate from or combined with reports of the hospitals.

(b) A hospital itself may be a subsidiary to or under the control of a large organization such as a university, governmental entity or parent corporation. It is typical in such situations for hospitals to receive services from these related organizations. Examples of services received are: administration; purchasing; general accounting; and menu planning. In addition, related organizations lease property, plant and equipment to hospitals, as well as paying for various other items, such as insurance. The related organization then usually charges for the service either directly or through a management fee. To be included as Costs Related to Patient Care, all such charges must be similar to those which would have been charged if the transacting organizations were not related. The direct charges must be recorded in the appropriate cost centers as billed, and the management fee must be distributed to the functional centers where services are provided. The hospital shall maintain documentation of the actual management service for which a management fee is recorded.

(c) Disclosure of information by hospitals dealing with related firm(s):

1. For the purpose of insuring prudent buying, hospitals shall report the existence of a related organization and each type of service provided, to the Division, if the total transactions amount to greater than $10,000 per year.

2. Hospitals may be related to one or more separate organizations if:

i. The hospital controls through contracts or other legal documents the authority to direct the separate organizations' management or policies;

ii. The separate organization controls through contracts or other legal documents the authority to direct the hospitals' management or policies; and/or

iii. The hospital is for all practical purposes the primary beneficiary of the separate organization.

(d) At the Division's request relevant information reported to the Division may include:

1. The nature of the legal relationship between the hospital and the related firm(s);

2. Frequency of business transactions between the hospital and the firm(s);

3. Purchase or lease contractual arrangements between the hospital and firm(s);

4. The amount of money involved; and

5. The financial statements of all related organizations.

10:52–6.13 Financial elements (generally)

The financial elements of the rates shall include the reasonable cost of the following: direct patient care; depreciation expense and interest payments; paid taxes, excluding income taxes; education, research and training programs, not otherwise paid for by the State; preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements; reasonable working capital; and where applicable and appropriate, reasonable return on investment. All non-direct costs must be allocated based upon the proportion of Medicaid recipients serviced by the hospital.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

10:52–6.14 Services related to Medicaid patient care

(a) Services related to Medicaid Patient Care include Direct Patient Care; Paid Taxes excluding Income Taxes; and Educational, Research and Training Programs as further defined in N.J.A.C. 10:52–6.14 through 6.21.

(b) Services Related to Patient Care include Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services. Costs Related to Medicaid Patient Care include salaries and wages, physician compensation, employee fringe benefits, medical and surgical supplies, drugs, non-medical and non-surgical supplies, purchased services and other direct expenses and major moveable equipment costs as determined in accordance with N.J.A.C. 10:52–6.22 through 6.26.

(c) All non-physician services and supplies provided to hospital inpatients, whether provided directly by the hospital or by a vendor, shall be considered services and costs related to patient care.

(d) All costs of services and supplies purchased from a vendor shall be subject to review for reasonableness by the Division.

10:52–6.15 Medicaid direct patient care

Medicaid direct patient care is the provision by a hospital of medically necessary and appropriate health care services to a Medicaid recipient.

10:52–6.16 Paid taxes

Taxes are monies paid to a governmental unit for conducting business related to direct patient care within its jurisdiction. Taxes are a financial element of the Preliminary Cost Base except for Federal, State, or local income, excess profit, or franchise taxes, taxes on property not used for direct patient care, and interest and/or penalties paid thereon. Taxes related to financing of operations through the issuance of bonds, property transfers, issuance or transfer of stocks, and the like, are not classified as taxes; rather, they shall be amortized or depreciated with the cost of the security or asset. Sales and real estate taxes paid by a hospital in the provision of Services Related to Patient Care shall be included as Paid Taxes. All sales and real estate taxes for Services Related to Patient Care shall be reported

in the General Administrative Services cost center and also reported separately from other classifications of expense. Employment related taxes, such as FICA, Unemployment Compensation, and Workers' Compensation, shall be classified as employee fringe benefits for all employees, including hospital-based physicians. Monies received by a hospital which chooses to self-insure in lieu of payment of Unemployment Compensation taxes and the associated administrative costs of such a self-insurance program are included as financial elements and classified as employee fringe benefits, if such monies are reasonably related to the hospital's unemployment compensation experience.

10:52–6.17 Educational, research and training program

(a) Educational program costs are the costs incurred by a hospital in the provision of a formally organized, planned program of study in a health service profession approved by an organization which recognizes the professional stature of health services education programs at the national level, net of any grants, tuition, and/or donations received for this purpose. To the extent that approved residencies for primary care physicians require training in ambulatory care facilities associated with a hospital, such reasonable expenses are included. Costs incurred by a hospital for direct patient care services rendered by medical, nursing, or allied health school personnel through an approved program in the hospital are financial elements provided that such costs would be included as financial elements if directly incurred by the hospital rather than under such arrangements. If not salaried or paid a stipend by the hospital, students shall not be considered as functioning in an employee capacity and thus no dollar amount shall be imputed and reported for their services.

(b) Research program costs are those costs incurred by a hospital in systematic, intensive study directed toward a better scientific knowledge of the provision of health care services in a program of the National Institutes of Health or other program approved by the Commission. Specific purpose grants or other funds received to offset the costs of such programs from the Federal government, New Jersey State government, New Jersey Heart Association, or other governmental or charitable organizations sponsoring such programs are applied to offset Costs Related to Medicaid Patient Care.

(c) Training program costs are the costs of providing to employees orientation or other health care related training, including inservice and on-the-job training, primarily designed to benefit the hospital by helping employees better perform their assigned tasks. The costs of providing such training shall be classified as administrative expense. Costs of training and/or educational programs which primarily benefit the employee (for example, tuition reimbursement programs) rather than the hospital shall be classified as employee fringe benefits and shall be reported as such in the appropriate cost centers.

10:52–6.18 Capital facilities

(a) With respect to Buildings and Fixed Equipment, the cost of Capital Facilities used for Services Related to Medicaid Patient Care, except for Major Moveable Equipment as defined in N.J.A.C. 10:52–6.19, are included as financial elements for all hospitals through a Capital Facilities Allowance.

(b) The amount of Revenue Related to Patient Care prospectively included for Capital Facilities in a hospital's Schedule of Rates is to be funded in the form of cash and/or investments in the Internally Generated Plant Replacement and Renovation Fund (Plant Fund).

10:52–6.19 Major moveable equipment

(a) Major Moveable Equipment includes straight-line depreciation costs on owned or capitalized leased Major Moveable Equipment plus a Price Level Depreciation Allowance in excess of this historical depreciation and operating lease/rent payments relative to Major Moveable Equipment utilized for Services Related to Patient Care. Leased Major Moveable Equipment is to be capitalized or reported as operating lease costs in accordance with (GAAP).

1. Major Moveable Equipment Costs so determined are reported as a Natural Classification of Expense of each cost center.

2. Major Moveable Equipment utilized by more than one functional cost center must be assigned to the using cost centers based on an estimate of each center's utilization.

3. Capitalized repair and installation costs shall be included with the cost of the equipment.

4. Interest associated with capitalized financing purchases or leases shall be excluded and reported as reconciling items, since the Internally Generated Major Moveable Equipment Replacement Fund is established to provide sufficient funds to replace purchased equipment or meet installment payments for financed equipment (both principal and interest).

10:52–6.20 through 10:52–6.21 (Reserved)

10:52–6.22 Natural classifications of expense

(a) Salaries and wages, including stipends, payable in cash, for services performed by an employee for a hospital (except a physician, including compensation for time not worked such as on call) vacation, holiday and sickpay or the monetary value assigned to direct services provided to the hospital by a person performing in an employee relationship are considered remuneration. Monetary value shall not be assigned to the services of students or other volunteer workers. All labor costs (including deferred income which qualifies as pension costs) shall be included in the accounting period during which the employee accrues the payment for their services.

(b) The following applies to the Physician Compensation—Hospital Component:

1. That portion of compensation for a physician's (M.D., D.O., D.D.S./M.D.) activities, provided through agreement with a hospital, representing services which are not directly related to an identifiable part of the medical care of an individual patient is the hospital component of physician compensation, and must be split between salaries and fees. Hospital services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as a part of the physician's hospital service activities. The allocation of physician compensation between hospital and professional components and documentation thereof is to be in accordance with Medicare HIM–15, section 2108, incorporated herein by reference, for provider component. To obtain the Medicare HIM–15 document or other Medicare manuals write to:

Department of Health and Human Services
Health Care Financing Administration
Division of Medicare
Regional Office 2
26 Federal Plaza
New York, New York 10278

(c) The following applies to the Physician Compensation—Professional Component:

1. That portion of compensation for a physician's services provided through agreement with a hospital pertaining to activities which are directly related to the medical care of an individual patient is the professional component of physician compensation (for example, remuneration for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his or her treatment) and must be split between salaries and fees. The allocation of physician compensation between hospital professional components and documentation thereof is to be in accordance with Medicare HIM–15, section 2108. For the address for obtaining Medicare documents, see (b) above.

(d) Employee Fringe Benefits are amounts paid to or on behalf of an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.

1. Fringe Benefits associated with physicians shall be reported with physician's compensation.

2. Pensions, annuities and deferred income arrangement costs for past and current services shall be accounted for and reported in accordance with Employee Retirement Insurance and Security Act (ERISA) and Internal Revenue Service (IRS) requirements. Employee Fringe Benefits include: FICA; State and Federal unemployment insurance; disability insurance; life insurance; employee health insurance; retirement (net of actuarial and realized gains on the investment of related funds); Workers' Compensation insurance; other payroll related employee benefits; tuition reimbursement and other training; moving expenses of new employees of a non-recurring nature; the cost of providing free or subsidized meals or cost to the employee at less than charges to employees; employee parking lot costs net of any revenue received for operation of the facility, and other non-payroll employee benefits.

3. The cost of providing health care services to employees shall be included in classifications of expense in various cost centers providing the funds. Such costs will be factored into the Preliminary Cost Base and Schedule of Rates by certain revenue adjustments. Where a hospital elects to self-insure for Workers' Compensation or unemployment insurance, costs reported shall be the amounts set aside for that accounting period plus associated administrative costs, where a separate fund was established, to the actual amounts of claims paid during the accounting year if a fund is not established. Where a hospital provides free or subsidized health care services to employees or physicians, the hospital's customary charges shall be generated and accounted for separately as personnel health allowances.

4. In order to preserve comparability of hospital expenses for provision of direct patient care, purchased employee health insurance expenses shall be reported as a separate cost center and shall not be distributed to the labor costs of each center. Employee Fringe Benefits shall be assigned to the cost center in which the employee's compensation is reported on the following basis:

Benefit	Basis of Assignment
FICA—non-physician and physician	Direct Cost
All other Payroll Related Benefits including Unemployment Insurance, Disability Insurance, Worker's Compensation and Pension and Retirement	Salaries
Life Insurance	Salaries or FTEs
Employee Education and Training	FTEs
Room and Board	FTEs
Cafeteria	FTEs
Parking Lot	FTEs

(e) Other Direct Expenses include all other direct non-capital operating expenses not classified elsewhere and reported for Costs Related to Patient Care. Other Direct Expenses include the following utilities; non-physician professional fees; licensing fees; dues assessments; travel; postage; printing and duplicating costs; outside training sessions; subscriptions; paid taxes as defined in N.J.A.C. 10:52–3.16; and insurance, other than employee fringe benefit insurance programs.

10:52–6.23 Medical and Surgical Supplies

(a) Medical and Surgical Supplies are medically necessary supplies, appliances, and minor moveable equipment (as defined in N.J.A.C. 10:52–6.8) furnished by, used at, and reported by a hospital for the care and treatment of a patient during a patient's episode of hospital care. Medically necessary supplies exclude all supplies furnished by a hospital but used by a patient after his episode of care except those items where it would be medically unreasonable to limit the patient's use of the item to his episode of hospital care (see N.J.A.C. 10:52–6.8 for the reporting of minor moveable equipment). The fair market value of donated Medical and Surgical Supplies is assigned to this classification if the commodity would otherwise be purchased by the hospital.

(b) Medical and Surgical Supplies include prosthetic devices, surgical supplies, anesthetic materials, oxygen and other medical gases, intravenous solutions, drugs including medically prescribed food supplements, biologicals, admission kits furnished by the hospital to inpatients not possessing such materials, and other medical care materials. The purchase cost of blood and blood components shall be excluded.

(c) The invoice/inventory cost and related revenue of all Medical and Surgical Supplies for which a separate charge is made to a patient for the use or consumption of the supply must be reported in the Medical and Surgical Supplies or Drugs Sold to Patients cost and revenue centers.

(d) Medical and Surgical Supplies issued by Central Supply Services or Pharmacy for which a separate charge is not made to a patient must be accounted for as an interdepartmental transfer at invoice/inventory cost to the cost center using the supplies and materials. The cost of reusable patient non-charge items used by more than one functional center must remain in or be transferred to the Central Supply Services cost center. The cost of reusable patient non-charged items used by one functional center should be reported in that center. The cost of other Medical and Surgical Supplies not requisitioned from Central Supply Services and for which a separate charge is not made to a patient must be reported in the functional cost center in which the supplies and/or materials are consumed.

(e) The overhead associated with the issuing of Medical and Surgical Supplies shall be reported in the Central Supply Services or Pharmacy cost centers. Except for reusable supplies in (d) above and differences between beginning and end of year inventories, no Medical and Surgical Supplies shall be reported in the Central Supply Services or Pharmacy cost centers.

10:52–6.24 Non–Medical and Non–Surgical Supplies

Non–Medical and Non–Surgical Supplies include the invoice/inventory cost of supplies, instruments, and minor equipment (other than Medical and Surgical Supplies) required for the operation of a hospital for purposes other than the direct provision of care to a patient are reported in the using cost and revenue centers. All rebates and quantity purchase discounts shall be offset against these costs.

10:52–6.25 Purchased Services

Purchased Services include the cost of all services purchased that could be accomplished by a hospital's own employees but for which the hospital elects to contract (not necessarily with a formal contract). All physician services shall be classified as physician compensation.

10:52–6.26 Major Moveable Equipment

Major Moveable Equipment, as defined in N.J.A.C. 10:52–6.8 are expenses to be included in the costs of each center at historical depreciation costs (for both owned and capitalized leased equipment) plus a price level replacement cost premium, as discussed in N.J.A.C. 10:52–6.8 and operating lease expenses. Interest expense incurred through purchase or capitalized leases of Major Moveable Equipment shall not be included with Major Moveable Equipment costs since the use of price level depreciation of such equipment for the financial elements is intended to replace this financial requirement of hospitals and provide adequate funds to replace equipment at the expiration of useful life.

10:52–6.27 Reports of costs and revenues

(a) The financial elements shall take into account a facility's income from all sources, including specific purpose grants and other funds from governmental sources, but excluding income and principal from board or donor restricted funds, gifts and special fund raising projects. Expenses incurred and revenues generated by a hospital for items not included in the definitions of Services Related to Patient Care (that is Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services) shall be classified as either other operating expenses and revenues or non-operating revenue. These expenses and revenues shall be accounted for separately to determine if and how they shall be applied to Costs Related to Patient Care and the Capital Facilities Allowance to determine the hospital's total financial elements or the Current Cost Base. (For Preliminary Cost Bases established using data from all Other Operating and Non–Operating Revenues and Expenses reported as Standard Hospital Accounting and Rate Evaluation (SHARE) cost center costs and "expense recoveries" shall be treated as Case B, as defined in (a)2 below). There are three cases into which such reconciliations are classified:

1. Case A—Expenses and revenues related to activities which the hospital has selected to engage in but which are not an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other. Gains are applied as reductions to the Current Cost Base used to determine hospital payment rates, but any losses are not applied.

2. Case B—Expenses and revenues related to activities which the hospital has elected to engage in and which are an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other. Losses are applied as increases to the Current Cost Base and gains are applied as reductions.

3. Case C—Expenses and revenues related to activities which are specifically excluded under the State rules. Expenses and revenues shall not be netted against each other. Neither gains nor losses shall be applied in determination of the Current Cost Base.

(b) Items of other operating expense and revenue shall be excluded from Services Related to Patient Care reporting centers. Other operating expenses and revenues so determined, in addition to non-operating revenues, shall be classified to account for all revenue and expense transactions of the hospital's Unrestricted Fund per the hospital's financial statements. Accounting differences between the hospital's financial statements and the Financial Elements Report shall be reconciled.

(c) Other operating expenses and revenues and non-operating revenues shall be categorized below as:

1. Excluded health care services;
2. Education and research;
3. Sales and services not related to patient care;
4. Patient convenience items;
5. Administrative items; and
6. Other income.

(d) Expenses and revenues of these items are netted against each other and the resulting total gains subtracted from or total losses added to Costs Related to Patient Care and the Capital Facilities Allowance to determine the hospital's Current Cost Base, depending on the Case (A, B, or C) into which the item is classified in N.J.A.C. 10:52–6.27 through 6.33. Items not listed in N.J.A.C. 10:52–6.27 through 6.33 shall be assigned to the case whose definition in (c) above best matches the nature of the item.

10:52–6.28 Excluded Health Care Services

(a) Non–Acute Care Services provided by a hospital such as skilled nursing care (approved or unapproved), intermediate care, residential care services, long-term psychiatric care and long-term rehabilitation and intermediate care services are not properly acute hospital functions, and hence shall be excluded and treated as Case C. Sufficient accounting records shall be maintained to account for the costs of such operations and such costs shall be excluded from Costs Related to Patient Care by cost center per N.J.A.C. 10:52–5.11 and 5.13.

(b) Organs acquired by a hospital and donated to a pool or patient at another hospital are not properly service related to care of patients at the donating hospital, and hence costs and revenues shall not be included in the service definitions. The acquisition costs incurred shall be accounted for in accordance with the definition of the Organ Acquisition cost center but not reported therein. However, costs of such donated organs shall be applied as increases to Costs Related to Patient Care and Revenues and shall be applied as offsets (Case B).

(c) In order to encourage hospital solicitation of blood donations, the purchase cost of whole blood or the equivalent units of blood extender and/or plasma shall be excluded and treated as Case C.

(d) When a hospital utilizes the laboratory, data processing, physical therapy department, or other services of a hospital, such costs shall not be included in the Costs Related to Patient Care of the hospital providing the services. The associated costs (including overhead) and revenue shall be excluded from the definitions of those centers in the providing hospital and treated as Case B.

(e) When a physician's compensation arrangement with a hospital requires some or all of the physician's fees received directly from patients to be turned over to the hospital, such fees shall not be included in Revenue Related to Patient Care and are treated as Case B.

(f) The cost and revenue related to excluded ambulatory services outpatient renal and home dialysis shall be treated as Case C. Revenues and expenses are netted, and neither gains nor losses shall be added to the Preliminary Cost Base. Sufficient accounting records shall be maintained to account for the costs of such operations and such direct and indirect cost shall be excluded from Costs Related to Patient Care.

(g) Concerning the following excluded ambulatory services:

1. The revenues and expenses associated with the provision of HealthStart Maternity Care Health Support Services shall be treated as Case C, netted against each other, with neither gains nor losses added to the Preliminary Cost Base.

2. As to HealthStart Pediatric Continuity of Care, in hospitals with salaried pediatricians, revenues and expenses associated with the non-institutional Medicaid capitated fee shall be treated as Case C and netted against each other. Gains and losses shall be excluded from the Preliminary Cost Base.

10:52–6.29 Education and Research

(a) Approved Education and Research Income such as grants, or contract payments, tuitions and fees received as direct support for approved educational and research programs (with the exception of those from the Graduate Medical Education Program for primary care residency programs in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology) (see N.J.A.C. 10:52–6.73) are used to offset such expenses and treated as Case B. Transfers of Specific Purpose Fund Revenues to the Unrestricted Fund shall be reported as non-operating revenue.

(b) Non–Approved Education and Research (not approved in accordance with N.J.A.C. 10:52–6.17) costs and revenues up to the amount of such costs are excluded. Overhead expenses shall be included in the costs of such program as Case A.

(c) Salaried house physicians hired by the hospital to supplement house coverage of attending physicians or patient units such as residents of non-hospital programs shall be included as Case B. Coverage of emergency services and other ambulatory and ancillary services by such physicians shall be included in the cost center definition of these services.

10:52–6.30 Sales and services not related to patient care

(a) Provision of General Services to an External Organization: The provision of data processing, laundry, housekeeping, managerial or other general services by a hospital to an organization other than another health care facility shall be excluded and treated as Case A. Costs of such arrangements shall include associated overhead and be reported in accordance with the reporting of related organizations (see N.J.A.C. 10:52–6.12).

(b) Sale of Medical Supplies (other than for an episode of hospital care) to patients such as take-home drugs, excluding those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care, and others shall be excluded. Take-home supplies for renal dialysis and home health care shall be included when included in the provisions of Medicare HIM–29 and HIM–11 (Case A). For the address for obtaining Medicare documents, see N.J.A.C. 10:52–6.22(b).

(c) Sale of scrap revenue shall be excluded from the revenue center and treated as Case B.

(d) Medical Records Transcription for patients, their legal advocates, or other non-hospital personnel shall be excluded. Costs (to be reported to the revenue received unless direct costing is available) and revenue shall be treated as Case A.

(e) Cafeteria operations, including vending machines, shall be treated as Case C, except for the subsidization of employee meals and meals for students in approved programs. Cafeteria operating losses shall be apportioned among employees, students and others. Subsidization of employee (including resident) meals shall be included as an employee fringe benefit. Subsidization of student meals shall be included as other direct expenses in either EDU or GME cost centers.

(f) Gift and Coffee Shops revenue and expense (including sales tax expense) as well as other activities which may be supported by volunteers shall be excluded from Services Related to Patient Care. Net gains from the operation of gift and coffee shops operated by volunteers shall not be offset against Costs Related to Patient Care (Case C).

(g) Services Rendered to Staff physicians by a hospital which normally would be incurred in a physician's private practice, such as the provision of medical secretarial services, shall be excluded and treated as Case C so long as the physician's compensation is not provided through agreement with a hospital.

(h) Parking lot or parking garage expenses and revenues at the site of the hospital shall be netted and the remainder apportioned between employees and others. The provision of parking facilities to:

1. Employees shall be included—Losses incurred from the operation of an employee parking lot shall be included as an employee fringe benefit;

2. Staff physicians parking shall be included and treated as Case B; and

3. Others shall be included as Case B if the hospital's charge for parking is not substantially inconsistent with other parking facilities in the community where the hospital is located. If the Commission determines that the hospital's parking charges are not competitive with other parking facilities, the provision of parking to others shall be treated as Case C.

(i) Non–Patient Room and Board expenses and revenues shall be netted and apportioned among employees, students and others. Sufficient accounting records shall be maintained to identify all related expenses as well as the number of persons housed. The provision of Room and Board to:

1. Employees and residents (including rotating residents who spend some portion of their residency at the hospital) shall be included. Losses incurred from housing an employee shall be included as an employee fringe benefit as Case B, see Section 6.22(d).

2. Students shall be included if in an approved educational program. Losses incurred from housing a student shall be assigned to Nursing and Allied Health Education (EDU) N.J.A.C. 10:52–6.72 and Graduate Medical Education (GME) Case B, see N.J.A.C. 10:52–6.73, or Non–Approved Education and Research as Case A.

3. Others not involved with the patient services of the hospital shall be excluded (Case A).

10:52–6.31 Patient convenience items

(a) Television and Radio provided to patients shall be excluded and net gains or losses from such services shall be treated as Case C.

(b) Telephone and Telegraph services provided to patients, including the appropriate portion of the hospital's switchboard costs shall be excluded and net gains or losses from such services treated as Case C.

(c) Luxury Meals and Items provided to patients or guests shall be excluded and treated as Case A.

(d) Non–Patient Room Rental Income generated from boarders related to or visitors of a patient shall be excluded from Revenue Related to Patient Care and treated as Case B.

(e) Private–Duty Nursing Services when provided through the hospital at the request of the patient and not prescribed by the attending physician shall be excluded and treated as Case C.

(f) Private Room Differential Income above a hospital's most common charge for a semi-private room for similar routine services, when specifically requested by the patient shall be excluded and treated as Case C. When ordered by the attending physician for medical necessity, income shall be excluded and treated as Case C. Hospitals should maintain separate revenue classifications for medically necessary and patient convenience private room revenue. Patients admitted or transferred to private rooms because of the unavailability of semi-private rooms shall be charged at the semi-private room rate, with a courtesy allowance (Policy Discount) generated for the differential. No attempt shall be made to identify private room Routine Service cost differentials.

10:52–6.32 Administrative items

(a) Administrative Expense Exclusions, as listed in this section, shall not be included in Costs Related to Patient Care and, as such, shall not be included in expenses defined as General Administrative Services (Case C);

1. Life insurance premiums for employees where the hospital is the direct beneficiary;

2. Stockholders servicing costs, such as those incurred to schedule and hold annual meetings;

3. Advertising costs, conducted by hospital personnel or agents of the hospital, which are directed at increasing utilization or medical staff membership, except where attempts to increase medical staff membership is for the procurement of a scarce medical service needed in the service area of the hospital;

4. Costs of membership in organizations not related to the development and operation of the hospital and the rendering of patient care services (for example social or fraternal organizations) shall not be included as an employee fringe benefit; and

5. Monies paid by a hospital to the home office, corporate or order headquarters for:

i. Non-patient care related enterprises;

ii. Abandoned home office planning costs for construction of a new facility; or

iii. The imputed value of services performed by non-paid workers in the case of religious orders.

(b) Income and Other Taxes including penalties for late payment of taxes (see N.J.A.C. 10:52–6.16 for full description) shall not be included as Costs Related to Patient Care and, as such, shall not be included in expenses defined as General Administrative Services (see N.J.A.C. 10:52–6.74).

(c) Purchase Discounts, revenue from rebates and quantity discounts shall be reported as expense recoveries.

(d) Non–Capital Interest Expenses (interest other than interest or Capital Facilities or Major Moveable Equipment) shall be excluded from Costs Related to Patient Care since short-term borrowing, etc. is addressed through the Financial Element Working Capital Requirements (see N.J.A.C. 10:52–6.27(a)) (Case C).

(e) Interest Expense for Major Moveable Equipment shall be excluded from Costs Related to Patient Care and treated as Case C. However, hospitals under the "Conditional Accept" or "Not Accept" options, may appeal to the Director to have this interest expense or the interest expense in (d) above included in their PCB.

10:52–6.33 Non-operating revenues (net of expenses)

(a) Income, net of expenses, or Investment in Rental Property to physicians or others shall be excluded from Revenue Related to Patient Care and treated as Case A.

(b) Income or Investment, net of transaction expense, of Operating Fund and/or interest income from financial charges on delinquent accounts receivable shall be applied as offsets against Costs Related to Patient Care and treated as Case B.

(c) Income or Investments, net of transaction expense, of Board Designated Funds shall not be included in Costs Related to Patient Care and treated as Case C.

(d) Unrestricted Income from Donor Restricted Plant and Endorsement Funds shall not be included in Revenue Related to Patient Care and treated as Case C.

(e) Transfer from Restricted Funds, other than Specified Purpose Funds (that is, expenditures from principal and

interest on gifts which are donor restricted) shall not be included as Revenue Related to Patient Care and treated as Case C.

(f) Unrestricted Donations, net of fund raising costs, shall not be included at Revenue Related to Patient Care and treated as Case C.

(g) Transfer of Specific Purpose Funds to the Unrestricted Fund and Specific Purpose Grants and other funds received from the Federal Government, New Jersey State Government, New Jersey Heart Association, or other governmental or charitable organizations shall be offset against Costs Related to Patient Care (with the exception of those from the Graduate Medical Education Program for primary care residency programs in Family Practice, Internal Medicine, Pediatrics or Obstetric/Gynecology). However, grants on behalf of the medically indigent shall be reported as contra-deducted from Gross Revenue Related to Patient Care (operating). "Seed Money" received with a grant shall be similarly offset against operating expenses unless this results in grants being withheld from New Jersey institutions (Case B).

(h) Primary Care Residency Specific Purpose Grants and income from primary care residency specific purpose funds (that is grants for the support of LCGME approved residency program in Internal Medicine, Pediatrics, Obstetrics/Gynecology and Family Practice) shall not offset the costs of such programs and treated as Case C.

(i) Interest Income on Trustee-held funds related to borrowings or loans is a Case B, unless a hospital is prohibited from using the funds to offset current debt service obligations. If the hospital is prohibited from using the funds, the interest and income earned shall be a Case C until these funds are released for the hospital's benefit.

10:52–6.34 Reporting of costs and revenues

Costs and Revenues Related to Patient Care shall be reported in accordance with N.J.A.C. 10:52–6.35 through 6.79.

10:52–6.35 Medical–Surgical Acute Care Units (MSA)

(a) The functions of Medical–Surgical Acute Care Units (MSA) are as follows:

1. Medical–Surgical Acute Care Units provide care to patients on the basis of physicians' orders and approved nursing care plans. Medical–Surgical Acute Care shall include the cost and revenue associated with services to all patients treated in beds normally designated as Medical–Surgical, regardless of the clinical specialty of attending physicians or age of the patient. Include the cost and revenue of beds designated as definitive observation or intermediate care (such as, "step down") beds.

2. Revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) shall be reported here, and also reported as reconciling items. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

3. Functions include serving and feeding of patients; collecting sputum, urine, and feces samples; monitoring of vital signs; operating of specialized equipment related to this function; preparing of equipment and assisting physicians during patient examination and treatment; changing dressings, cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medications; infusing intravenous fluids; answering patients' call signals; and keeping patients' room (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

10:52–6.36 Obstetric Acute Care Unit (OBS)

(a) The functions of Obstetric Acute Care Unit (OBS) are as follows:

1. The provision of care to the mother before, during and following delivery on the basis of physicians' orders and approved nursing care plans shall be provided in the Obstetric Acute Care Unit. Obstetrics may include services to clean gynecological patients treated in beds licensed by the Department of Health as obstetrics.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) shall be reported as reconciling items. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

3. Functions shall include: instructing of mothers in postnatal care and care of the newborn; feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital signs; operating specialized equipment related to this function; preparing of equipment and assistance of physicians in changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction of drugs; administering specified medications; infusing intravenous fluids; answering patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) Patient Days.

10:52–6.37 Pediatric Acute Care Units (PED)

(a) The functions of Pediatric Acute Care Units (PED) are as follows:

1. Pediatric Acute Care Units provide care to Pediatric patients (normally children less than 14 years of age and including "boarder patients") in Pediatric nursing units on the basis of physicians' orders and approved nursing care plans. Pediatric Acute Care shall include the costs and revenues associated with all patients, regardless of age, treated on units normally reserved for the care of patients less than 14 years of age and shall not include the costs and revenues of treating patients less than 14 years of age in Medical–Surgical and Psychiatric Acute Units. Cost and Revenue associated with swing beds (that is, those not designated (excluding for one type of patient) [1] shall be apportioned among the appropriate Routine Service Centers, as defined in N.J.A.C. 10:52–6.35 through 6.78, based on actual utilization.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) shall be reported as reconciling items. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

3. Functions shall include the following: serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medications; infusing intravenous fluids; answering patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

[1] So in original.

10:52–6.38 Psychiatric Acute Care Units (PSA)

(a) The functions of Psychiatric Acute Care Units (PSA) are as follows:

1. Psychiatric Acute Care Units provide care to patients admitted for diagnosis as well as treatment on the basis of physicians' orders and approved nursing care plans. The units shall be staffed with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Psychiatric Acute Care shall include only the costs and revenues associated with services to psychiatric patients in a unit solely designated to the care of the acute mentally ill.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) shall be reported as a reconciling item. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 10:52–6.23. Special Services consumed by patients on Psychiatric Acute Care Units shall be reported in the Psychiatric/Psychological Services Center.

3. Functions shall include the following: serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital signs; operating of specialized equipment related to this function; preparing of equipment and assistance of physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medications; infusing intravenous fluids; answering of patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

10:52–6.39 Burn Care Units (BCU)

(a) The functions of Burn Care Units (BCU) are as follows:

1. Burn Care Units provide care to severely burned patients that are of a more intensive nature than the usual acute nursing care provided in medical-surgical units. Burn Care Units shall be staffed with specially trained nursing personnel and contain specialized support equipment for burn patients who require intensified, comprehensive observation and care. Burn Care Units shall include only the costs and revenues associated with services to burn patients in a unit solely designated for this purpose. Burn patients not in a unit solely designated for this purpose shall be reported in the Intensive Care Units (ICU) center.

2. Functions shall include the following: serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital signs; operating specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medications; infusing intravenous fluids; answering of patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

10:52–6.40 Intensive Care Units (ICU)

(a) The functions of the Intensive Care Units (ICU) are as follows:

1. Intensive Care Units provide nursing care to patients who, because of surgery, shock, trauma, serious injury or life threatening conditions, require intensified comprehensive observation and care. These units shall be staffed with specially trained nursing personnel and contain specialized equipment for patient monitoring and life support systems. Intensive Care Units include Stroke Care, Pediatric, Intensive Care, Burn Care (not classified in BCU), Medical and Surgical Intensive Care and mixed Intensive Care–Coronary Care Units, but excludes units solely designated 25 Coronary Care Units or Neonatal Intensive Care Units. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

2. Functions shall include the following: monitoring patients' progress; operating specialized equipment; assisting physicians during examinations and treatments; dispensing prescribed medications, including intravenous solutions; cleansing and dressing incisions and wounds; maintaining patients' charts; and requisitioning and storing medical supplies and drugs kept in these units.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

10:52–6.41 Coronary Care Units (CCU)

(a) The functions of the Coronary Care Units (CCU) are as follows:

1. Coronary Care Units provide the delivery of care of a more specialized nature than that provided to the usual Medical, Surgical, and Pediatric patient. The unit shall contain monitoring and specialized support or treatment equipment for patients who, because of heart attacks, open heart surgery or life threatening conditions, require intensified, comprehensive observation and care and shall be staffed with specially trained nursing personnel. Coronary patients treated in mixed Intensive/Coronary Care Units shall be included in the Intensive Care Units (ICU) center. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

2. Functions shall include the following: serving and feeding of patients; collection of sputum, urine and feces samples; monitoring of vital signs; operating of specialized equipment related to this function; preparing of equipment and assistance of physicians during patient examination and treatment; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medications; infusing intravenous fluids; answering of patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

10:52–6.42 Neonatal Intensive Care Units (NNI)

(a) The functions of the Neonatal Intensive Care Units (NNI) are as follows:

1. A Neonatal Intensive Care Unit provides care to newborn infants that is of a more intensive nature than care provided in Pediatric Acute or Newborn Nursing Units. Care shall be provided on the basis of physicians' orders and approved nursing care plans. The units shall be staffed with specially trained nursing personnel and contain specialized support equipment for treatment of those newborn infants who require intensified, comprehensive observation and care. Neonatal Intensive Care Units shall be designated perinatal centers by the Department of Health. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

2. Functions shall include the following: feeding infants; collecting sputum, urine and feces samples; monitoring vital signs; operating specialized equipment needed for this function; preparing equipment and assisting physicians during infant examination and treatment; changing dressings and cleansing wounds and incisions; bathing infants; observing patients for reaction to drugs and administering specified medications including intravenous fluids.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

10:52–6.43 Newborn Nursery (NBN)

(a) The functions of the Newborn Nursery (NBN) are as follows:

1. A Newborn Nursery shall provide nursing care to newborns on the basis of pediatricians' orders and approved nursing care plans. Newborn Nursery should include all normal care newborns. Bassinets maintained for infants other than newborn (pediatrics) shall be included here. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

2. Functions shall include the following: constant observation of newborns; checking on progress of newborns; feeding and diapering newborns; assisting pediatricians during examination and treatment; operating special equipment; dispensing prescribed medications; and educating new mothers on infant care; maintaining newborns' charts; requisitioning and sorting medical supplies, drugs and infants formulae; and scheduling newborns for ancillary services.

3. Costs associated with units designated by the Department of Health as perinatal centers shall be reported in this cost center.

(b) Units of Service: Patient and Patient Days (counted comparably with non-newborn patients).

10:52–6.44 Emergency Services (EMR)

(a) The functions of the Emergency Services (EMR) are as follows:

1. Emergency Services provide emergency treatment to sick and injured patients requiring medical care on an immediate, unscheduled basis. Also included shall be non-emergency type patients who request outpatient treatment on an unscheduled basis in the Emergency Room.

2. Functions shall include the following: assisting critical patients to and from vehicles; expediting treatment for critical patients for ancillary services; coordinating emergency admissions; operation of an ambulance; operation of cast room; assisting physicians in emergency treatment; cleaning and dressing wounds; applying casts; maintaining aseptic conditions; monitoring vital signs.

(b) Units of Service: Visits.

10:52–6.45 Anesthesiology Services (ANS)

(a) The functions of the Anesthesiology Services (ANS) are as follows:

1. Anesthesiology Services are a hospital based service conducted under the direction of either a qualified physician trained in anesthesiology (that is, an anesthesiologist) or the operating surgeon.

2. Anesthesia gases and other anesthesia supplies and minor moveable equipment if not individually charged to the patient shall be reported in Anesthesiology. The cost of anesthesiologists' compensation and any other costs associated with anesthesiologists' practice (that is, employees of the physician, and supplies the physician purchases through their private practice, etc.), as well as the revenue generated by the anesthesiologist and anyone under the physician's employment, shall be reported to the extent that the anesthesiologists' compensation is provided through agreement with the hospital. Cost associated with nurse anesthetists employed by the hospital shall also be reported here.

3. Functions shall include the following: obtaining laboratory findings and patient's anesthetic history prior to administration of anesthetics; administering anesthetics; recording the kind and amount of anesthetic administered; observing patient's condition until all effects of anesthesia have passed; accompanying patient to recovery room or intensive care unit; administering treatment to patients having symptoms of post-anesthetic complication; prescribing pre and post-anesthesia medications; and carrying out safeguards for administration of anesthetics.

(b) Units of Services: Anesthesia Minutes.

10:52–6.46 Cardiac Catheterization (CCA)

(a) The functions of the Cardiac Catheterization (CCA) are as follows:

1. Cardiac Catheterization includes all invasive cardiac diagnostic procedures performed in dedicated or non-dedicated cardiac catheterization or coronary angiographic laboratories. Cardiac catheterization procedures are performed in a limited number of hospitals that are designated as cardiac diagnostic facilities or regional cardiac surgical centers. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

2. Functions shall include the following: preparation of patients for testing; explaining test procedures to patients; inspecting, testing and maintaining special equipment; and achieving optimal quality physiological and coronary angiographic studies.

(b) Units of Services: Procedures.

10:52–6.47 Delivery and Labor Rooms (DEL)

(a) The functions of the Delivery and Labor Rooms (DEL) are as follows:

1. Delivery and Labor Rooms provide nursing care by specially trained personnel to obstetrical patients and patients having gynecological procedures performed in the Delivery Suite. Caesarean sections shall be included if they are performed in a delivery room. Costs of routine housekeeping functions (that is, those conducted throughout the hospital) performed by delivery and labor personnel shall be included in the housekeeping center. Only specialized clean-up procedures unique to Delivery and Labor Rooms functions shall be included in Delivery and Labor. Medical and Surgical Supplies shall be reported in accordance with N.J.A.C. 10:52–6.23.

2. Functions shall include the following: maintaining aseptic conditions; enforcing of safety rules and standards; arranging sterile setup for deliveries; monitoring patient and caring for patient's needs while in labor and in recovery; transporting patients within the labor and delivery suite; preparing for delivery; comforting the patient during delivery; assisting the physician during delivery; fetal heart monitoring; amniocentesis (if performed in the delivery suite); circumcision of male newborns; and cleaning up after delivery to the extent of preparation for pickup and disposal of used linen, instruments, utensils and waste.

(b) Units of Services:

1. Deliveries;
2. Gynecological Procedures.

10:52–6.48 Dialysis (DIA)

(a) The functions of the Dialysis (DIA) are as follows: Dialysis is a hospital based service employing the use of an artificial kidney machine for cleansing the blood. Dialysis shall include both hemodialysis and peritoneal dialysis procedures. The inclusion of Dialysis take-home supplies, if not individually charged, and other costs and revenues shall be in accordance with Medicare HIM 29 instructions. Dialysis take-home and other supplies individually charged for shall be reported in Medical and Surgical Supplies Sold, whether sold or rented, if such supplies shall be included per Medicare HIM 29. For the address for obtaining Medicare documents, see N.J.A.C. 10:52–6.22(b).

(b) Units of Services: Treatments.

10:52–6.49 Drugs Sold to Patients (DRU)

(a) The functions of the Drugs Sold to Patients (DRU) are as follows:

1. The Drugs Sold to Patients center shall be used for the accumulation of the invoice cost and corresponding revenue of all pharmaceuticals and intravenous solutions individually charged to patients including chemotherapy drugs. The invoice/inventory cost of non-charged drugs (pharmaceuticals) or intravenous solutions issued by the Pharmacy to other centers shall be transferred to the using centers, preferably on a monthly basis. If such items are sold in other centers, the cost of those items must be transferred to this center. The overhead cost of preparing and issuing drugs and intravenous solutions sold directly to patients must be accumulated in the Pharmacy center.

2. Medically prescribed food supplements, if charged directly to patients shall be included in Drugs Sold to Patients. Cost and revenue associated with blood (that is, whole blood and packed red cells) and blood components (that is, fibrinogen, and gamma globulin) shall be excluded from the Laboratory center and reported as reconciling items. Excluded from this center are the cost and revenue associated with drugs furnished to a patient for use after his episode of hospital care (except for those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care). Included in the center are the cost and revenue associated with drugs and intravenous solutions sold under renal dialysis and home health agency programs as specified in Medicare HIM 29 and HIM 11. For the address for obtaining Medicare documents, see N.J.A.C. 10:52–6.22(b).

10:52–6.50 Electrocardiology (EKG)

(a) The functions of the Electrocardiology (EKG) are as follows:

1. Electrocardiology is a hospital service that utilizes specialized electrical equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments under the direction of a qualified physician. The cost incurred and revenue generated by personnel or equipment for electrocardiology procedures continuously available as part of the functions of other centers (that is, Intensive or Coronary Care Units, Operating and Recovery Rooms, Diagnostic Radiology, and Cardiac Catheterization) shall be included in those centers.

2. The cost of cardiologists' compensation as well as the revenue generated by cardiologists shall be reported to the extent that the cardiologists' compensation is provided through agreement with the hospital.

3. Functions shall include the following: wheeling portable equipment to patient's bedside; conducting stress tests; explaining test procedures to patients; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; and attaching and removing electrodes from patients.

(b) Units of Service: Electrocardiograms.

10:52–6.51 Laboratory (LAB)

(a) The functions of the Laboratory (LAB) are as follows:

1. Laboratory is normally a hospital based pathological or clinical service conducted under the direction of a qualified pathologist. All laboratory operations, including subsidiary laboratories of the hospital, shall be included here, whether purchased from outside or performed by the hospital laboratory. Services provided for outside institutions shall be excluded and reported as reconciling items. All fields of laboratory work, such as Autopsy, Blood Bank, Chemistry, Cytology, Hematology, Histology, Immunology, and Microbiology shall be included. Laboratory work in poison and infection control, epidemiology (including nursing epidemiology work), and coagulation testing shall be included. Infection control officer costs not related to laboratory work shall be apportioned to benefiting patient care areas. The revenue and cost of performing blood gas analyses are to be included in the Respiratory therapy center, and pathologist compensation costs and revenues related to Nuclear Medicine shall be included in that center.

2. The procuring (drawing), receiving, storing, typing and crossmatching of whole blood, blood components and blood products shall be included in Laboratory. Purchase cost of and patient payments for blood and blood products shall be excluded and reported. The costs associated with procuring blood donations shall be included in Laboratory.

(b) Units of Service: College of American Pathologists Relative Value Units.

10:52–6.52 Medical and Surgical Supplies Sold (MSS)

(a) The functions of the Medical and Surgical Supplies Sold (MSS) are as follows:

1. The Medical and Surgical Supplies Sold center is used for the accumulation of the invoice cost and revenue of all medical and surgical supplies and equipment sold or rented directly to patients. The invoice/inventory cost of non-charged supplies and equipment issued by the Central Supply Service Center to other centers shall be transferred to the using centers, preferably on a monthly basis. If such items are sold in other hospital centers, the cost and revenue of those items must be transferred to this center. The overhead cost of preparing and issuing medical and surgical supplies and equipment sold or rented directly to patients must be accumulated in the Central Supply Services center.

2. Excluded from this center shall be the cost and revenue associated with supplies furnished to a patient for use after his or her episode of hospital care (except for those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care, for example, pacemakers, permanent prostheses, etc., and take-home Dialysis and Home Health Agency supplies included per Medicare HIM 29 and HIM 11). The costs and revenues associated with such items shall be reported as reconciling items. For the address for obtaining Medicare documents, see N.J.A.C. 10:52–6.22(b).

10:52–6.53 Neurology, Diagnostic (NEU)

(a) The functions of the Neurology, Diagnostic (NEU) are as follows:

1. This center shall provide diagnostic neurology services such as electroencephalography and electromyography under the direction of a qualified physician. Specialized equipment is used to record electromotive variations in brain waves and to record electrical potential variation for diagnosis of muscular and nervous disorders.

2. The cost of compensation of physicians involved in diagnostic neurology, as well as the revenue generated by these physicians for their activities shall be reported to the extent that their compensation is provided through agreement with the hospital.

3. Functions shall include the following: Wheeling portable equipment to patient's bedside; explaining test procedures to patient; operating specialized equipment; inspecting, testing and maintaining special equipment; and attaching and removing electrodes from patients.

(b) Units of Service:

1. EEGs;

2. EMGs.

10:52–6.54 Nuclear Medicine (NMD)

(a) The functions of the Nuclear Medicine (NMD) are as follows:

1. Nuclear Medicine is a hospital based service which provides diagnosis and treatment of patients by injectible or ingestible radioactive isotopes under the direction of a qualified physician.

2. Costs shared with Therapeutic Radiology, Diagnostic Radiology, and Laboratory, such as radiologists, pathologists, radiology office expense and maintenance costs shall be apportioned among the benefiting centers. The cost of compensation of physicians involved in Nuclear Medicine, as well as the revenue they generate, shall be reported to the extent that their compensation is provided through agreement with the hospital.

3. Functions shall include the following: Consultation with patient and attending physician; radioactive waste disposal; and storage of radioactive materials.

(b) Units of Service: Procedures.

10:52–6.55 Occupational and Recreational Therapy (OCC)

(a) The functions of the Occupational and Recreational Therapy (OCC) are as follows:

1. Occupational therapy is the application of purposeful, goal-oriented activity, under the direction of a registered therapist and medical director, in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health.

2. Recreational therapy is the employment of sports, dramatics, arts and other recreational programs, under the direction of a registered therapist and medical director to stimulate the patient's recovery rate.

3. The cost of compensation of physicians involved in occupational and recreational therapy as well as the revenue generated by these physicians for their activities shall be reported to the extent that their compensation is provided through agreement with the hospital.

4. Functions shall include the following: Education and training in activities of daily living (ADL); the design, fabrication, and application of splints; sensorimotor activities; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaption of physical environments for the handicapped; continuing and organizing instrumental and vocal musical activities; and directing activities of volunteers in respect to these functions. These services shall be provided to individuals or groups.

(b) Units of Service: Visits.

10:52–6.56 Operating and Recovery Rooms (ORR)

(a) The functions of the Operating and Recovery Rooms (ORR) are as follows:

1. Operating and Recovery Rooms provide surgical services to both inpatients and outpatients. These rooms shall be staffed with specially trained personnel who assist the surgeon during operations and the patient immediately thereafter. Cost of and revenue from rooms used for minor and ambulatory surgery or special procedures (for example, cytoscopy, endoscopy, gastroscopy) other than a surgical clinic shall be included here. The cost and revenue associated with surgical dental services provided to patients shall also be included.

2. Costs of routine housekeeping functions (that is, those conducted throughout the hospital) performed by Operating and Recovery Room personnel shall be reported in the Housekeeping Center. Only the cost of specialized cleaning procedures unique to Operating and Recovery Rooms and performed by Operating and Recovery Room personnel shall be reported in the Operating and Recovery Room Center. Medical and Surgical Supplies shall be reported per N.J.A.C. 10:52–6.23.

3. Functions shall include the following: The requisitioning of instruments, utensils, medical supplies, and drugs required for surgery; inspecting, testing and maintaining specialized surgical equipment; maintaining aseptic techniques; enforcing of safety rules and standards; assisting in preparing patients for surgery (only while in the operating room; exclude preparation work done on patient floors); assisting the surgeon during operations; counting of sponges, needles and instruments used during operations; preparing patients for transportation to recovery room; monitoring patient and caring for patient's needs while recovering from anesthesia; and pickup and disposal of used linen, instruments, utensils and waste.

(b) Units of Service:

1. Procedures;

2. Minutes.

10:52–6.57 Organ Acquisition (ORG)

(a) The functions of the Organ Acquisition (ORG) are as follows:

1. These centers acquire, store, and preserve all kidneys and other human organs for their eventual transplantation to patients of the hospital. All direct costs incurred by the Laboratory, Operating and Recovery Rooms and other hospital departments in acquiring organs shall be transferred to the Organ Acquisition Center. The costs and revenues (or value of credits) of acquiring organs for a pool or for transplantation to a patient of another hospital shall be reported as an organ donation reconciliation.

2. Functions shall include the following: Conducting sterile autopsies to obtain organs; purchasing of organs from a central pool; harvesting; and preservation of organs.

(b) Units of Service: Transplants.

10:52–6.58 Physical Therapy (PHT)

(a) The functions of the Physical Therapy (PHT) are as follows:

1. Physical Therapy is a service employing therapeutic exercises and massage, and utilizing effective properties of light, heat, cold, water, and electricity in diagnosis and rehabilitation of patients with neuromuscular, orthopedic, and other disabilities under the medical direction of a psychiatrist or other qualified physician. Physical Therapy services shall include the provision of clinical and constructive services and the direction of patients in the use, function, and care of braces, artificial limbs, and other devices. This center shall include the cost of physical therapy, related medical supplies, materials and equipment not requisitioned from Central Supply Services and for which a separate charge is not made to a patient.

2. The cost of all supplies and equipment furnished to a patient for use after his episode of hospital care (for example, crutches, elastic bandages, etc.) but excluding items where it would be medically unreasonable to limit the patient's use of the item to his episode of hospital care (for example, customized braces, prostheses, etc.) shall be excluded from this center.

3. Functions shall include the following: Prescription of therapeutic exercises; counseling of patients and relatives; organizing and conducting medically-prescribed physical therapy programs; application of diagnostic muscle tests; administration of whirlpool and compact baths; changing linen on beds and treatment tables; and assisting patients in changing clothes.

(b) Units of Service: Visits.

10:52–6.59 Psychiatric/Psychological Services (PSY)

(a) The functions of the Psychiatric/Psychological Services (PSY) are as follows:

1. This center provides psychiatric and psychological services, such as individual, group, and family therapy to adults, adolescents and families of hospital patients, but excluding costs and revenues associated with psychiatric/psychological clinic visits. Costs and revenues to be reported here include those related to the compensation of psychiatrists, psychologists, or psychiatric social workers to the extent that such compensation is provided through agreement with the hospital.

2. Functions shall include the following: Evaluation and psychotherapy provided to inpatients; emergency room psychiatric/psychological care; biofeedback training; psychological testing; and shock therapy.

(b) Units of Service: Hours (spent with patients).

10:52–6.60 Radiology, Diagnostic (RAD)

(a) The functions of the Radiology, Diagnostic (RAD) are as follows:

1. Diagnostic Radiology is normally a hospital based service conducted under the direction of a qualified radiologist, and shall include procedures, such as angiograms (except coronary angiograms), arteriograms, computerized axial tomography scans, and echograms (ultrasonography).

2. Cost shared with therapeutic Radiology and Nuclear Medicine such as radiologists, radiology office expense and maintenance costs shall be apportioned among the benefiting cost centers. The salaries of personnel, such as bioengineers, assigned substantially full-time for the purpose of maintaining, testing and inspecting Diagnostic Radiology equipment, shall be reported here.

3. The cost of compensation of radiologists as well as the revenue they generate shall be reported in this center to the extent that their compensation is provided through agreement with the hospital.

4. Functions shall include the following: Taking, processing, examining and interpreting radiographs and fluorographs; consultation with patient and attending physicians; storage of radioactive materials; and radioactive waste disposal.

(b) Units of Service: California Medical Association Relative Value Units.

10:52–6.61 Respiratory Therapy (RSP)

(a) The functions of the Respiratory Therapy (RSP) are as follows:

1. Respiratory therapy is a hospital based service for diagnosis and treatment of pulmonary diseases. This shall include pulmonary function testing, the administration of oxygen and certain potent drugs through inhalation or positive pressure, and other forms of rehabilitative therapy, under the direction of a qualified physician. Pulmonary function testing is the testing and thorough measurement of inhaled and exhaled gases and analysis of blood, and evaluation of the patient's ability to exchange oxygen and other gases.

2. The cost of compensation of pulmonary physicians involved in rendering respiratory diagnostic and therapeutic services, as well as the revenue generated by these physicians for such activities, shall be reported to the extent that these physicians' compensation is provided through agreement with the hospital.

3. The costs of and revenue generated from all gases administered to patients shall be included in this center, excluding the costs and revenue associated with gases administered as part of the anesthetizing process which are included in the Anesthesiology Center.

4. Functions shall include the following: Transporting therapy equipment to patient's bedside; setting up and operating various types of oxygen and other therapeutic gas and mist inhalation equipment; blood gas testing; observing and instructing patients during therapy; visiting all assigned respiratory cases to insure that physicians' orders are being carried out; inspecting and testing equipment; and enforcing safety rules.

(b) Units of Service: Treatments

10:52–6.62 Speech–Language Pathology and Audiology (SPA)

(a) The functions of the Speech–Language Pathology and Audiology (SPA) are as follows:

1. Speech Pathology provides therapeutic treatment for disorders of production, reception and perception of speech and language. Audiology provides and coordinates services to persons with impaired peripheral and/or central auditory function. The detection and management of any existing communicating handicaps centering in whole or in part on the hearing function. Such activities shall be coordinated with medical evaluation and treatment of hospital patients.

2. Functions shall include the following: Audiologic assessment (including basic audiometric testing and screening, examination for site of lesions, non-organic hearing loss and various parameters of auditory processing abilities essential for communication function); hearing aid evaluation, selection, orientation, adjustment and other technical related services; audiologic habilitation and rehabilitation including the development, remediation or conservation of receptive and expressing language abilities; demonstrating and evaluating amplification devices and altering systems; evaluating excessively noisy environments; determining through interviews and special tests the etiology, history and severity of speech disorders; and special speech, hearing and language remedial procedures, counseling and guidance.

(b) Units of Services: Visits.

10:52–6.63 Therapeutic Radiology (THR)

(a) The functions of the Therapeutic Radiology (THR) are as follows:

1. Therapeutic Radiology is a hospital based service providing therapy by radium and other radioactive substances, including cobalt therapy and linear accelerator treatment, under the direction of a qualified radiologist.

2. Costs shared with Diagnostic Radiology and Nuclear Medicine, such as radiologists, radiology office expense and maintenance costs including salaries of bioengineering personnel shall be apportioned among the benefiting centers.

3. The cost of compensation of radiologists involved in therapeutic radiology as well as the revenue they generate shall be reported to the extent that their compensation is provided through agreement with the hospital.

4. Functions shall include the following: Consultation with patients and attending physician; operation of specialized equipment; storage of radioactive material; disposal of radioactive waste; and inspecting, testing and maintaining specialized equipment.

(b) Units of Service: Procedures.

10:52–6.64 Central Supply Services (CSS)

(a) The functions of the Central Supply Services (CSS) are as follows:

1. Central Supply Services shall prepare and issue medical and surgical supplies and equipment, except pharmaceuticals and intravenous solutions to patients and to other cost centers.

2. The invoice cost of non-charged supplies and equipment issued to other centers shall be transferred to the using centers, preferably on a monthly basis. The invoice cost of charged medical supplies shall be transferred to the Medical and Surgical Supplies Sold Center, preferably on a monthly basis.

3. The cost of non-charged reusable medical supplies and equipment requisitioned from CSS by different centers (for example, respirators) shall be reported in the Central Supply Service Center. Costs associated with non-charged reusable medical supplies and equipment requisitioned from only one center shall be reported in that center.

4. Functions shall include the following: Requisitioning and issuing of appropriate supply items required for patient care; preparing sterile irrigating solutions; collecting, assembling, sterilizing, and redistributing reusable items; and cleaning, assembling, maintaining, and issuing portable apparatus.

(b) Statistics: Costed [1] Requisitions of All Medical and Surgical Supplies.

[1] So in original.

10:52–6.65 Dietary (DTY)

(a) The functions of the Dietary (DTY) are as follows:

1. Dietary shall be responsible for the procurement, storage, processing of food, delivery and collecting of trays and nourishment to nursing units or outpatient centers. Costs of delivery of trays to the patient once trays have been prepared or have arrived at the nursing unit shall be reported in the appropriate Routine Service center. The cost of preparing meals for cafeterias, residents, students, visitors, or house physicians shall be reported for luxury and guest meals as per N.J.A.C. 10:52–6.27 through 6.33. Cost and Revenue of food supplements when charged to patients shall be reported in the Drugs Sold to Patients center.

2. Functions shall include the following: Preparing diet manuals; recommending diets; preparing selective menus for various diet requirements; recording diet history; nutrition counseling; determining patient food preferences as to type and method of preparation; food storage and preparations; transportation of food trays to and from nursing units; stocking formula room; cashiering; dishwashing; and maintaining sanitary standards in all facilities.

(b) Statistics: Meals.

10:52–6.66 Housekeeping (HKP)

(a) The functions of the Housekeeping (HKP) are as follows:

1. Housekeeping shall be responsible for the maintenance of a clean and sanitary environment in the institution. The cost of routine cleansing of all areas, excluding Dietary (DTY) and Boiler Room (RPM) shall be included in housekeeping. The cost of housekeeping to non-acute care areas, gift and coffee shops, offices rented or maintained for fund raising, or non-approved education and research programs, and for the room and board of employees, students, or others, as well as the expense and revenue of providing housekeeping to entities outside of the hospital shall not be reported here but shall be reported in their appropriate cost center as in N.J.A.C. 10:52–6.35 through 6.78. Specialized clean-up activities associated with direct care of patients in nursing units and outpatient and ancillary centers shall be reported in those centers (see N.J.A.C. 10:52–3.35 through 6.79).

2. Functions shall include the following: Maid service; janitorial service; transporting trash to plant staging areas; mopping, stripping and waxing floors; washing of walls, ceilings, partitions and windows (inside and outside); stripping, disinfecting and making beds; and moving furniture and fixtures.

(b) Statistics: Hours of Services.

10:52–6.67 Laundry and Linen (L & L)

(a) The functions of the Laundry and Linen (L & L) are as follows: Laundry and Linen is responsible for the requisitioning, laundering, distributing, controlling and mending linen, bedding, wearing apparel and disposable linen substitutes used by the hospital. The purchase cost and maintenance of all wearing apparel, as well as all linen, bedding, etc., shall be included. The cost of providing laundry and linen services to non-acute care units and for the room and board of employees, students, and others should not be included in this center.

(b) Statistics: Pounds of Laundry.

10:52–6.68 Medical Records (MRD)

(a) The functions of the Medical Records (MRD) are as follows:

1. Medical Records shall be responsible for creating and maintaining a medical record for all patients and for maintaining a tumor registry in accordance with Department of Health requirements (N.J.A.C. 8:43G–21.2(a)). The revenue and costs associated with medical records transcriptions for persons outside of the hospital shall be reported as reconciling items.

2. Functions shall include the following: Coding; typing; abstracting; filing; indexing; accessing; preparing birth and death certificates; processing court and other types of inquiries; maintaining and reporting of data such as patient days, visits, ancillary services and statistics by patient, disease, physician and operation; and coordinating the flow of statistics with certain hospital centers.

(b) Statistics: Percentage of time spent.

10:52–6.69 Pharmacy (PHM)

(a) The functions of the Pharmacy (PHM) are as follows:

1. The Pharmacy procures, preserves, stores, compounds, manufactures, packages, controls, assays, dispenses, and distributes medications (including intravenous solutions) for inpatients and outpatients under the jurisdiction of a licensed pharmacist. Pharmacy services shall include the maintaining of separate stocks of commonly used items in designated areas.

2. The invoice cost of non-charged pharmaceuticals issued to other cost centers shall be transferred to the using cost centers, preferably on a monthly basis. The invoice cost of charged pharmaceuticals and intravenous solutions shall be transferred to the Drugs Sold to Patients center, preferably on a monthly basis.

3. Functions shall include the following: Development and maintenance of formulary(ies) established by the medical staff and consultation and advice to medical and nursing staff on drug therapy; adding drugs to intravenous solutions; determining incompatibility of drug combinations; and stocking floor drugs and dispensing machines.

(b) Statistics: Costed [1] Requisition of All Drugs.

[1] So in original.

10:52–6.70 Social Services (SOC)

(a) The functions of the Social Services (SOC) are as follows:

1. Social Services shall obtain, analyze, interpret social and economic information to assist in diagnosis, treatment and rehabilitation of patients. These services shall include: counseling of staff and patients in case units and group units; participation in development of community social and health programs and community education. Revenues received by hospitals shall not be reported here, but shall be reported with the routine or ambulatory revenue centers where social services were provided and billed.

2. Functions shall include the following: Interviewing of patients and relatives to obtain a social history relevant to medical problems and planning; interpreting problems of social situations as they relate to medical condition and/or hospitalization; arranging for post discharge care of chronically ill; collecting and revising information on community health and welfare resources.

(b) Statistics: Percentage of time spent.

10:52–6.71 Research (RSH)

(a) The functions of the Research (RSH) are as follows:

1. This center shall administer, manage, and carry on research projects of the National Institutes of Health or other projects approved by the Commission in approved research. Approved research shall be reported pursuant to N.J.A.C. 10:52–6.27 through 6.29. Separate accounting shall be maintained for each research activity in accordance with relevant contracts, grant agreements, or because of restrictions made on donations. Revenue received for research activities such as specific purpose grants shall be recorded as reconciling items. This center shall include expenses related to fellowships.

10:52–6.72 Nursing and Allied Health Education (EDU)

(a) The functions of the Nursing and Allied Health Education (EDU) that are included in this cost center are as follows:

1. The Nursing and Allied Health Education Center provides organized programs, approved by an organization which recognizes the professional stature of health services educational programs at the national level, of nursing and medical related clinical education other than for physicians. Hospitals may either operate a school or provide the clinical training activities where a degree is issued by a college or university.

2. Expenses related to the upkeep of student rooms and dormitories.

3. Functions shall include the following: Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and educational problems; selecting faculty personnel; assigning and supervising students in providing medical or nursing care to selected patients; and administering aptitude and other tests for counseling and selection purposes.

10:52–6.73 Graduate Medical Education (GME)

(a) The functions of the Graduate Medical Education (GME) are as follows:

1. Graduate Medical Education shall provide an organized program of graduate medical clinical education to interns and residents. A medical residency training program must be approved by the Liaison Committee on Graduate Medical Education or, in the case of osteopathic residencies, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Residency programs in the field of dentistry in a hospital must have the approval of the Council on Dental Education of the American Dental Association.

2. Included here shall be expenses related to the office of the Director of Medical Education and the housing and board of residents. Expenses associated with fellowships are to be included in the Research (RSH) Center.

3. Functions shall include the following: Selecting qualified students, providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and education problems; and assigning and supervising students.

10:52–6.74 General Administrative Services (GAM)

(a) The functions of the General Administrative Services (GAM) are as follows:

1. General Administrative Services shall be those services associated with the overall direction and administration of the institution at all levels that are not readily distinguishable between inpatient and outpatient services. Expenses and revenues directly associated with services not related to patient care (for example, data processing services sold to outside organizations, administrative personnel responsible for the operation of skilled nursing facilities, and other exclusions) shall be reported as reconciling items. Detailed reporting of certain Administrative Service expenses shall be provided.

2. General Administrative Services include:

i. Governing Board;

ii. Office of Hospital Administrator Medical Administration;

iii. Medical Administration;

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

v. Personnel;

vi. Public Relations;

vii. Communications;

viii. Management Engineering;

ix. Health Sciences Library;

x. Auxiliary Groups;

xi. Data Processing;

xii. Purchasing and Stores;

xiii. Internal Audit;

xiv. Postage;

xv. Medical Library;

xvi. Medical Photography and Illustration;

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

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

xix. Security;

xx. Planning;

xxi. Professional Association Memberships;

xxii. Legal and Audit Fees;

xxiii. Duplicating and Printing;

xxiv. Financial Administration;

xxv. Motor Pool; and

xxvi. Travel.

10:52–6.75 Inpatient Administrative Services (IAM)

(a) The functions of the Inpatient Administrative Services (IAM) are as follows:

1. Inpatient Administrative Services shall be those primarily associated with the overall direction and administration of inpatient services provided in the institution. For example, the hospital admitting office would be assigned to Inpatient Administrative Services, rather than General Administrative Services. Detailed reporting of certain Administrative Services expenses shall be provided per N.J.A.C. 8:31B–4.61 through 4.70, incorporated herein by reference.

10:52–6.76 Malpractice Insurance (MAL)

(a) The functions of the Malpractice Insurance (MAL) are as follows:

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

10:52–6.77 Employee Health Insurance (EHI)

(a) The functions of the Employee Health Insurance (EHI) are as follows:

1. Employee Health Insurance shall include all premium payments and associated costs with union or group health insurance for employees. Hospitals which are self-insured for employees health insurance shall report no insurance costs in this cost center. However, deductions from operating revenue for personal health programs shall be reported by cost center.

10:52–6.78 Repairs and Maintenance (RPM)

(a) The functions of the Repairs and Maintenance (RPM) are as follows:

1. The Repairs and Maintenance center shall be responsible for maintenance and operation of an institution's buildings and equipment in a state of readiness required to perform hospital operations. Repairs and Maintenance of physical plant not used for services related to patient care (for example, rental of apartments) shall be reported as reconciling items. Renovation of capital assets is to be distinguished from Repairs and Maintenance Expenses and capitalized with the asset according to the criteria described in 10:52–6.19.

2. The maintenance and repair of specialized equipment in areas such as Diagnostic Radiology, Therapeutic Radiology, or Laboratory shall report such costs in those centers. Biomedical engineers' expenses shall be in this cost center.

3. Functions shall include the following: All maintenance of buildings and plant equipment including painting; maintenance of moveable equipment to the extent done by institution employees; and minor improvements and renovation of buildings and plant equipment.

10:52–6.79 Utilities Cost (UTC)

(a) The functions of the Utilities Cost (UTC) are as follows:

1. The center shall be used to account for all utility costs such as electricity, gas, oil, disposal services and water. A breakdown of the cost and source of these utilities shall be provided.

2. Telephones shall be considered utilities and thus such costs and revenues shall not be reported in this center. Costs associated with utilities provided to buildings and areas not involved in patient care shall be excluded and reported as reconciling items.

SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

10:52–7.1 Diagnosis Related Groups (DRG)

(a) Diagnosis Related Groups (DRG) represent categories of hospital inpatients with similar clinical characteristics and, except for outliers, patients in each DRG can be expected to consume similar amounts of hospital resources. Assignment of a patient to a DRG requires the following information:

1. Principal diagnosis;
2. Secondary diagnosis;
3. Principal and other procedures;
4. Age;
5. Sex;
6. Discharge status; and
7. Birthweight (neonate): A newborn under 29 days of age.

(b) The appropriate classifications are reported here and these are the only classifications allowable for DRG assignment.

1. Principal diagnosis: The condition established after study shall be chiefly responsible for occasioning the admission of a patient to the hospital for care. The principal diagnosis must be coded using the International Classification of Diseases, 9th Revision, with Clinical Modifications (ICD–9–CM).

2. Secondary diagnosis: Conditions that exist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay. Diagnoses which have no bearing on the treatment received during a current hospital stay are not appropriate for use in DRG assignment. All secondary diagnoses must be coded using ICD–9–CM.

3. Principal and other procedures: Diagnostic and therapeutic procedures performed during a patient stay. All procedures must be coded using ICD–9–CM.

4. Age: Patient's chronological age at admission in years.

5. Sex: Patient's sex as male or female.

6. Discharge Status: The circumstances under which a patient left the hospital, coded as routine discharge to home, discharged against medical advice, transferred or died.

7. Birthweight: A newborn's weight in grams at birth.

8. Neonate: A newborn under 29 days of age.

(c) Admission: Patient hospitalized for a condition related to a recent spell of illness.

1. Patients who are treated and subsequently admitted through the emergency room shall be considered admitted to the hospital at the time the physician orders the admission. The cause of the admission shall be considered the cause of the emergency room treatment. Therefore, the course of treatment shall be considered one

admission. Services rendered in the emergency room shall be reflected in the inpatient record and the UB–82 claim form.

2. Similarly, a patient admitted for a course of treatment as a Same Day Surgery (SDS) patient, who subsequently is admitted from that mode of treatment shall be considered one admission. Services rendered in the SDS mode shall be reflected in the inpatient record and UB–82 claim form.

3. Readmissions are patients admitted to an acute care hospital at another time during the last seven days.

10:52–7.2 Calculation of payment rates

(a) Outliers are patients displaying atypical characteristics relative to other patients in a DRG. The three categories of outliers are defined and the methodology for outlier payment is established as follows.

1. High length of stay: Patients assigned to a DRG, but whose Length of Stay (LOS) is longer than the high LOS trim point.

i. The rate is the inlier rate per case plus a per diem for each acute day from the date of admission to the date of discharge.

2. Low length of stay: Patients assigned to a DRG, but whose Length of Stay (LOS) is shorter than the trim point.

i. Payment is limited to either the lower of the inlier rate per case or the sum of the acute days multiplied by the low per diem.

3. Transfer patients: Patients under medical advice requiring continued acute care who are transferred from one Acute Care Facility to another Acute Care Facility.

i. Where a patient's discharge status is that of a transfer to another acute care facility (inpatient), the rate is limited to the lower of the inlier rate per case or the sum of the acute days multiplied by the low outlier per diem. The hospital which received the transfer patient (and that patient is subsequently a non-transfer status discharge) will receive the appropriate rate per case or per diem based upon DRG assignment and trim point status.

4. The payment rates for DRGs with no base year experience will be calculated using Medicaid Statewide base year costs.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

10:52–7.3 List of Diagnosis Related Groups

(a) The following are Major Diagnostic Categories (Organ System Approach):

1. Diseases and Disorders of the Nervous System.

2. Diseases and Disorders of the Eye.

3. Diseases and Disorders of the Ear, Nose, Mouth and Throat.

4. Diseases and Disorders of the Respiratory System.

5. Diseases and Disorders of the Circulatory System.

6. Diseases and Disorders of the Digestive System.

7. Diseases and Disorders of the Hepatobiliary System and Pancreas.

8. Diseases and Disorders of the Musculoskeletal System and Connective Tissue.

9. Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.

10. Endocrine, Nutritional and Metabolic Diseases and Disorders.

11. Diseases and Disorders of the Kidney and Urinary Tract.

12. Diseases and Disorders of the Male Reproductive System.

13. Diseases and Disorders of the Female Reproductive System.

14. Pregnancy, Childbirth and the Puerperium.

15. Normal Newborns and Other Neonates with Certain Conditions Originating in the Perinatal Period.

16. Diseases and Disorders of Blood and Blood Forming Organs and Immunological Disorders.

17. Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms.

18. Infectious and Parasitic Diseases (Systemic or Unspecified Sites).

19. Mental Diseases and Disorders.

20. Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.

21. Injuries, Poisonings and Toxic Effects of Drugs.

22. Burns.

23. Factors Influencing Health Status and Other Contacts with Health Services.

24. Human Immunodeficiency Virus (HIV) Infections.

25. Multiple Significant Trauma.

(b) The following are abbreviations used in ICD–9–CM DRG English descriptors listed below.

1. w AGE 70 CC: Patients who are over age 70 and/or have a substantial complication or comorbidity.

2. wO AGE 70 CC: Patients who are age 0–70 and have no substantial complication or comorbidity.

3. w CC: Patients with a substantial complication or comorbidity.

4. wO CC: Patients without a substantial complication or comorbidity.

5. O.R. Procedures: therapeutic or diagnostic procedures generally performed in a fully equipped operating room (O.R.).

6. URI: Upper Respiratory Infection.

7. AMI: Acute Myocardial Infarction.

8. CHF: Congestive Heart Failure.

9. D & C: Dilation and Curettage.

10. FUO: Fever of Unknown Origin.

11. NEC: Not Elsewhere Classifiable.

SUBCHAPTER 8. BASIS OF SPECIFIC PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

10:52–8.1 Disproportionate share adjustment

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

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

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

(d) The Commissioner of the Department of Human Services may also designate a hospital as eligible for additional disproportionate share payments if it is determined that the hospital provides a high percentage of care (as defined in N.J.A.C. 10:52–8.2(a)4i(1)) in proportion to total operating revenue to patients with HIV, mental illness, tuberculosis, substance abuse and addiction or neonatal complexity. In addition, to be designated as eligible for this additional disproportionate share payment, the facility shall have a high Charity Care plus Medicaid utilization rate (as defined in N.J.A.C. 10:52–8.2(a)4i(1)). A facility shall further demonstrate a commitment to the establishment and operation of a managed care program for the uninsured and other low income persons.

Amended by R.1997 d.92, effective February 18, 1997.
See: 28 N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).
Substantially amended (d).
Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).
In (a), deleted the third sentence.

10:52–8.2 Method of payment

(a) The disproportionate share adjustment shall include an adjustment amount annually determined, as to (a)1 through 3 below, by the Commissioner of the Department of Health and Senior Services in consultation with the Commissioner of the Department of Human Services and, as to (a)4 through 6 below, by the Commissioner, Department of Human Services based upon a determination regarding payments for charity care. The annual DSH payments shall be calculated and distributed in accordance with all applicable Federal laws and regulations.

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

2. The recommendation from the Department of Health and Senior Services (DHSS) shall be calculated in the following manner pursuant to P.L. 1992, c.160 (N.J.S.A. 26:2H–18).

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

(1) The Essential Health Services Commission shall use the results of the charity care audit conducted as its definition of charity care incurred by all hospitals.

(2) The New Jersey Department of Health shall report to the Essential Health Services Commission, the results of its audit of New Jersey acute care hospital's charity care provided in the year per N.J.A.C. 8:31B–4.41 through 4.41N.

(A) For purposes of determining annual charity care costs, hospitals shall submit their audit lists per N.J.A.C. 8:31B–4.41A but may list their accounts by charges rather than the Medicaid rate.

(B) For purposes of determining annual charity care costs, the criteria in N.J.A.C. 8:31B–4.41D through 4.41L shall not apply to a patient who is investigated by a county adjuster and found to be

indigent by a court of competent jurisdiction pursuant to N.J.S.A. 30:4. A patient so found shall qualify for 100 percent charity care coverage. Hospitals with patients who qualify under this provision shall include the appropriate documentation from the court in the patient's file for audit.

(C) For purposes of determining annual charity care costs, hospitals may document New Jersey residency for patients in either of the following two ways: hospitals must document that the applicant was a New Jersey resident at the time he or she received services and had the intent to remain in the State. An out-of-State resident may apply for charity care if his or her services resulted from a situation requiring immediate medical care pursuant to N.J.A.C. 8:31B–4.41F.

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

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

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

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

(4) If a hospital's percentage of charity care costs in relation to their revenue cap is among the 80 percent of hospitals with the highest percentage of charity care, it is eligible to receive a Health Care Subsidy Fund Charity Care adjustment.

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

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

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

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

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

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

(A) The GME add-on shall be calculated as follows:

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

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

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

(B) The IME add-on shall be calculated as follows:

(I) For charity care payments made for January 1998 through June 1998, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the 1996 Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the 1996 Medicare submitted cost report. This charity care IME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996. (Charity care claims are priced at the Medicaid rate in effect when the services are rendered.) This adjustment shall be based on the percentage of inpatient charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

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

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

3. A hospital's eligibility for the Other Uncompensated Care Hospital Subsidy Fund payment shall be calculated using the following formula:

i. Hospital Specific Other Uncompensated Care for Year/Hospital Specific Revenue for Year = Hospital Specific Percentage of Other Uncompensated Care (% OUC). A hospital is eligible for a subsidy if, upon establishing rank order of the % OUC for all hospitals:

(1) In 1993, the hospital is among the 45 percent of hospitals with the highest % OUC;

(2) In 1994, the hospital is among the 30 percent of hospitals with the highest % OUC; and

(3) In 1995, the hospital is among the 15 percent of hospitals with the highest % OUC.

ii. The amount of the subsidy an eligible hospital shall receive shall be based on the following:

Hospital Specific Other Uncompensated Care for Year/Total Other Uncompensated Care for all Eligible Hospitals for Year multiplied by Total Amount of Subsidy Allocated for the Year = Hospital Specific Subsidy for the Year.

The monies in the Other Uncompensated Care component of the disproportionate share hospital subsidy account shall be distributed to eligible hospitals in accordance with the formulas provided in this section. In 1993, the fund shall distribute $100 million in subsidies to eligible hospitals; in 1994, the fund shall distribute $67 million to eligible hospitals; and in 1995, the fund shall distribute $33 million to eligible hospitals. For 1993, the formulas shall use 1991 Hospital Specific Other Uncompensated Care and Total Uncompensated Care for eligible hospitals and the hospital's PCB for "Hospital Specific Revenue for Year." In 1994 and 1995, the formulas shall use 1992 Other Uncompensated Care and Total Other Uncompensated Care for all eligible hospitals and the hospital's 1993 revenue cap established pursuant to P.L. 1992, c.160, section 3. (N.J.S.A. 26:2H–18).

iii. Other Uncompensated Care (OUC) shall be distributed to hospitals to meet the requirements of Chapter 160, Section 1d (N.J.S.A. 26:2H–18). OUC is defined as all costs not reimbursed by hospital payers excluding charity care, graduate medical education, discounts, bad debt, and reduction in Medicaid payments. The Department of Health (DOH), under the direction of the Essential Health Services Commission (EHSC), will calculate the actual OUC amounts for the purpose of determining the distribution of the OUC subsidy payments.

(1) In 1993, OUC subsidies shall be based upon actual 1991 OUC amounts.

(2) In 1994 and 1995, OUC subsidies shall be based upon actual 1992 OUC amounts.

(3) In 1994, interim OUC subsidy payments shall initially be based upon the projected 1992 OUC amounts determined by the DOH under Chapter 83 (N.J.S.A. 26:2H–1) for the rate year 1992; the actual 1992 OUC amounts shall be determined after October 1, 1994, when final 1992 data for all acute hospitals is available from the fiscal intermediary. After the actual 1992 OUC amounts are calculated by the DOH and approved by the EHSC, the 1994 OUC subsidy payments or other Medicaid payments shall be adjusted by making adjustments to the OUC or other DSH or Medicaid payments made by the Division of Medical Assistance and Health Services (DMAHS).

iv. The Chapter 83 (N.J.S.A. 26:2H–1) inpatient payments referenced in (a)3iii above, shall be based upon Diagnosis Related Groups (DRG) payments from the applicable rate year's uniform bill (UB) data submitted to the DOH under the former N.J.A.C. 8:31B–3.45.

(1) For 1993, total indirect costs from the 1991 pro forma final reconciliation shall be first apportioned to inpatients through application of the inpatient direct patient care cost (DPC) percentage, then apportioned to Medicare inpatients based upon the Medicare percentage of total DRG payments using UB data. The inpatient DPC percentage shall be derived by dividing total inpatient DRG payments into the sum of the following: total inpatient DRG payments plus patients with rates approved cost from the 1991 pro forma final reconciliation plus outpatients without rates approved cost from the 1991 pro forma final reconciliations by total inpatient DRG payments.

(2) For 1994, most 1992 indirect costs were volume variable and included in the DRG rates. For those 1992 indirect costs not allocated through the establishment of inpatient and outpatient rates, those "other" indirect costs will be considered fixed and will be allocated to inpatients through the inpatient DPC percentage, and apportioned to Medicare inpatients based upon the Medicare percentage of total DRG payments. The source of the 1992 "other" indirect costs shall be the 1992 Report 5, which expresses 1988 base year costs in 1992 dollars. Total 1992 DPC shall be established as follows: 1992 total inpatient DRG rates plus 1992 outpatient DPC. 1992 outpatient DPC shall be derived by running 1992 actual costs through the 1992 rate setting methodology, which allocates most indirect costs to both inpatient and outpatient rates.

(3) Inpatient Part B physician costs shall be removed since no comparable Medicare data on Medicare payments is available.

v. The DOH will apply the Federal Prospective Payment System (PPS) GROUPER and Pricer programs to determine DRG payments for the Medicare patients identified in (a)3iv above.

(1) The DOH will include "excluded unit" Medicare reimbursement in Medicare inpatient payments for the applicable rate year for those Medicare cases reimbursed under Chapter 83 (N.J.S.A. 26:2H–1) but not under PPS.

(2) The DOH will include the following data from the applicable rate year Medicare cost reports in order to determine the other components of Medicare inpatient payments:

(A) Excluded unit reimbursement;

(B) Pass-through payments; and

(C) Inpatient Part B physician costs.

vi. Chapter 83 (N.J.S.A. 26:2H–1) Medicare outpatient payments shall be based upon:

(1) For 1993, total Chapter 83 outpatient payments will be derived by adding total 1993 approved cost for outpatients with rates to total 1991 approved cost for all patients without rates. The source of this data shall be the 1991 pro forma final reconciliations. 1991 Chapter 83 outpatient payments for Medicare patients shall be derived by multiplying the 1991 Medicare outpatient revenue percentage by the total Chapter 83 payments.

(2) For 1994, 1992 actual outpatient DPC costs shall be used to determine Chapter 83 outpatient payments. These DPC costs shall include indirect costs allocated to outpatients, and shall be apportioned to Medicare patients by applying the actual 1992 cost-to-charge ratio to Medicare outpatient charges from the 1992 Medicare cost reports.

(3) For 1994, most 1992 indirect costs were volume variable and included in the outpatient rates. For those 1992 indirect costs not allocated through the establishment of inpatient and outpatient rates, those "other" indirect costs will be considered fixed and will be allocated to outpatients through the outpatient DPC percentage, and apportioned to Medicare outpatients based upon the Medicare percentage of total outpatient revenue. The source of the 1992 "other" indirect costs shall be 1992 Report 5, which expresses 1988 base year costs in 1992 dollars. The outpatient DPC shall be derived by allocating indirect costs to the inpatient and outpatient rates in accordance with the 1992 rate setting methodology. The outpatient DPC percentage shall be derived by dividing 1992 outpatient DPC into 1992 total DPC as defined in (a)3iv(2) above.

(4) Outpatient Part B physician costs shall be removed since no comparable Medicare data on payments is available.

vii. The DOH will use the following Medicare outpatient data from the applicable rate year Medicare cost reports:

(1) Medicare outpatient payments;

(2) Medicare outpatient revenue which shall be used to determine the Medicare outpatient percentages to apportion Chapter 83 (N.J.S.A. 26:2H–1) outpatient indirect costs; and

(3) Medicare outpatient Part B physician costs.

viii. The OUC formula is as follows: The sum of Chapter 83 (N.J.S.A. 26:2H–1) inpatient and outpatient payments as defined in (a)3iv and vi above, minus inpatient and outpatient payments as defined in (a)3v and vii above.

ix. The DOH will calculate the OUC subsidy payments based upon the formula in P.L. 1992, c.160, section 11 (N.J.S.A. 26:2H–18), as follows:

(1) In 1993, each hospital's actual 1991 OUC amount divided by its 1992 preliminary cost base shall yield a percentage called the OUC percentage. Forty-five percent of the hospitals with the highest OUC percentages will receive $100 million in OUC subsidy payments. For those hospitals qualifying for a share of the subsidy payments, in accordance with (a)3ix(2) below, each hospital's payment is determined by the hospital's OUC as a percentage of the sum of all eligible hospitals' OUC amounts; this hospital-specific percentage is multiplied by the Statewide subsidy amount to derive the hospital's subsidy payment.

(2) In 1994, each hospital's actual 1992 OUC amount divided by its 1993 revenue cap shall yield the OUC percentage. Thirty percent of the hospitals with the highest OUC percentage will receive $67 million in OUC subsidy payments. For those hospitals qualifying for a share of the subsidy payments, each hospital's payment is determined by the hospital's OUC as a percentage of the sum of all eligible hospitals' OUC amounts; this hospital-specific percentage is multiplied by the Statewide subsidy amount to derive the hospital's subsidy payment.

(3) In 1995, each hospital's actual 1992 OUC amount divided by its 1993 revenue cap shall yield the OUC percentage. Fifteen percent of the hospitals with the highest OUC percentages will receive $33 million in OUC subsidy payments. For those hospitals qualifying for a share of the subsidy payments, each hospital's payments is determined by the hospital's OUC as a percentage of the sum of all eligible hospitals' OUC amounts; this hospital-specific percentage is multiplied by the Statewide subsidy amount to derive the hospital's subsidy payment.

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

i. Payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the most recent calendar year hospital data available as of October 1 of each year for periods through State Fiscal Year 1999. Effective for periods after State Fiscal Year 1999, payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the most recent calendar year hospital data available as of February 1 of each State fiscal year preceding the distribution year. For the purpose of pricing the

problem billed cases listed at (a)4i(2)(A) below for periods prior to July 6, 1998, the Medicaid rate shall be defined as the rate in effect as of October 1 of each year preceding the distribution year. For the purpose of pricing the problem billed cases listed at (a)4i(2)(A) below effective on or after July 6, 1998, the Medicaid rate shall be defined as the rate in effect as of February 1 of each State fiscal year preceding the distribution year. Effective for payments on or after July 6, 1998, this payment shall no longer be distributed over a Calendar Year. Instead, it shall be distributed over the State Fiscal Year, July through June.

(1) For purposes of determining which hospitals are eligible for payment from the HRSF, a hospital shall satisfy both of the two following independent criteria:

(A) The hospital's cases for the seven categories listed at (a)4i(2)(A) below, priced at the Medicaid rate, divided by the hospital's Total Operating Revenue, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey hospitals receiving Medicaid payments. For periods in which the data source excludes GME and IME in the rate, the Medicaid rate shall be adjusted by hospital-specific GME and IME add-ons. The hospital-specific GME and IME add-ons shall be calculated as defined in (a)4i(4) below; and

(B) The hospital's charity care days plus the hospital's Medicaid and NJ KidCare-Plan A days, divided by the hospital's total days, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey hospitals receiving Medicaid and NJ KidCare-Plan A payments. For payments distributed in State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid and NJ KidCare-Plan A managed care days if the data is available by May 31, 1998. For payments distributed in State Fiscal Years after State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid and NJ KidCare-Plan A managed care days if the data is available by February 1 prior to the State fiscal year of distribution.

(2) The subsidy shall be an amount allocated by the Commissioner during the fiscal year for this purpose and shall be distributed in the following manner:

(A) The payments for admissions for the following categories are taken from the same calendar year hospital data as defined in (a)4i above maintained by the New Jersey Department of Health and Senior Services (DHSS):

HIV (MDC 24);

Mental Health (MDC 19);

Substance Abuse (MDC 20);

Complex Neonates (DRG 600 through 618, 622, 623, 626 or 627);

Tuberculosis as a major or minor diagnosis (ICD–9–CM; 010.0 through 018.9);

Mothers with substance abuse (MDC 14 with the following codes: ICD–9–CM; 6483,6555, 304, 305); and

HIV as a secondary diagnosis (excluding MDC 24; including ICD–9–CM; 0420 through 0422, 0429 through 0433, 0439, 0440, 0449).

(3) The funding for the subsidy shall be distributed among eligible facilities based upon the hospital's percentage of payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)4i(4) below, for patients with the categories in (a)4i(2)(A) above as a percentage of all payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)4i(4) below, for patients in these categories in eligible hospitals.

(4) For periods in which the data source excludes GME and IME costs in the Medicaid and NJ KidCare-Plan A fee-for-service rate, the rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified in this section, for periods through State Fiscal Year 1999, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. Unless otherwise specified in this section, effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid or NJ KidCare-Plan A rate. The add-ons shall be calculated as follows:

(A) A hospital-specific GME add-on shall be calculated based on the hospital-specific GME per discharge multiplied by the number of cases of the categories defined in (a)4i(2)(A) above. The hospital-specific GME per discharge shall be calculated based on the inpatient share of the aggregate approved GME amount from Worksheet E–3 Part IV of the Medicare submitted cost report divided by the hospital-specific total hospital discharges from Worksheet S–3 Part I of the Medicare submitted cost report.

(B) The hospital-specific IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the number of cases of the categories defined in (a)4i(2)(A) above, priced at the current available Medicaid inpatient rates. The components of the IME formula, IME intern and resident FTEs, and maintained beds shall be taken from the Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the Medicare submitted cost report used in the calculation.

5. Disproportionate Share Hospitals which service a large number of low income mentally ill or developmentally disabled clients may also be eligible to receive increased disproportionate share payment. The amount of payments to be made to facilities which serve a large number of mentally ill low income clients will be based upon recommendation by the Division of Mental Health and Hospitals within the Department of Human Services to the Commissioner of the Department of Human Services. This recommendation will identify hospitals essential to preserve the fragile network of mental health providers in the State. The Division of Developmental Disabilities may also recommend an additional payment to facilities who serve a large number of developmentally disabled clients. These additional payments will assure that these low income and special needs clients continue to have access to critical care.

i. The Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients shall be an amount allocated by the Commissioner during the fiscal year for this purpose. It shall be distributed in the following manner:

(1) 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 and Hospitals and a Short Term Care Facility (STCF) or a Child Community Inpatient Service (CCIS). Payments to 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.

(2) Hospitals who are not STCF or CCIS, but which are under contract with the Division of Mental Health and Hospitals 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.

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.

10:52–8.3 Calculation and distribution of disproportionate share hospital (DSH) payments as a result of hospital closure; purpose and procedure

(a) The purpose of this rule is to provide guidance to allocate and redistribute disproportionate share hospital (DSH) payments to provide for the patients who were served by the closed hospital. When a hospital closes, 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 that would have gone to the closed hospital will receive the closed hospital's allocation. In the event of any future hospital closings, DSH payments to the closed hospital will cease and State laws and/or rules will be enacted or promulgated, respectively, to specify the eligible hospitals and the calculation and distribution of the closed hospital's(s') DSH payment(s).

1. In (b) and (c) below, the reimbursement methodology for DSH applies exclusively to the closure of UHMC.

(b) For the 1998 Charity Care allocation, the Division shall exclude all data pertaining to United Hospitals Medical Center (UHMC).

(c) In calendar year 1998, and each year thereafter, when the source hospital data precedes calendar year 1997, an HRSF allocation that would have gone to UHMC shall be initially calculated. Then the reallocation of UHMC's calculated HRSF allocation shall be calculated and distributed to eligible disproportionate share hospitals 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-PS hospital data in the following manner:

1. DSHs eligible to receive a portion of UHMC's calculated HRSF allocation shall satisfy both of the two following independent criteria:

i. An eligible hospital shall draw its patients from the same neighborhoods, identified by zip codes, that UHMC served. Zip codes are included in the definition of UHMC's market area if they represent areas from which UHMC drew one percent or more of its adult admission or 2.5 percent or more of its pediatric admissions; or if UHMC's admissions represented five percent or more of admissions to all hospitals from that zip code.

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

2. The available Hospital Relief Subsidy Funds (HRSFs) to be reallocated shall be distributed among eligible hospitals based upon an eligible hospital's percentage of market share problem-billed admissions as a percentage of all market share problem-billed admissions of eligible hospitals. The reallocated funds shall be distributed on a monthly basis.

New Rule, R.1998 d.60, effective January 20, 1998.
See: 29 N.J.R. 4376(a), 30 N.J.R. 388(a).

SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

10:52–9.1 Review and appeal of rates

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

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

1. A request for a rate review must be submitted by a hospital in writing to the Department of Human Services, Division of Medical Assistance and Health Services, Administrative and Financial Services, PO Box 712, Mail Code #42, Trenton, New Jersey 08625–0712 within 20 calendar days after publication of the rates by the Department of Human Services (DHS).

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

2. The Division will not approve an increase in a hospital's rates unless the hospital demonstrates that it would sustain a marginal loss in providing inpatient services to Medicaid recipients at the rates under appeal even if it were an economically and efficiently operated hospital. Marginal loss is the amount by which a hospital's rate year's Medicaid reimbursement for inpatient services is expected to fall short of the incremental costs, defined as the variable or additional out-of-pocket costs, that the hospital expects to incur providing inpatient hospital services to Medicaid patients during the rate year. These incremental costs are over and above the inpatient costs the hospitals would expect to incur during the rate year even if it did not provide service to Medicaid patients. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid beneficiaries and the extent to which it has taken all reasonable steps to contain or reduce the costs of providing inpatient hospital services. The hospital may be required at a minimum to submit to the Department of Human Services, the following information:

i. Operational reviews;

ii. Efficiency studies and reports identifying opportunities for cost savings;

iii. Minutes of the meeting of the hospital's board of directors and board's finance committee;

iv. Reports of the Joint Commission on the Accreditation of Health Care Organizations;

v. Management letters;

vi. The hospital's strategic plans, long range plans, facilities plans and marketing plans;

vii. The hospital's annual report;

viii. Any analyses of the hospital's marginal cost in providing services to Medicaid or other categories of patients;

ix. Cost accounting documentation or reports pertaining to the hospital's cost incurred in treating Medicaid recipients or the comparative cost of treating Medicaid and other patients;

x. A copy of the hospital's most recent Medicare cost report with all supporting schedules;

xi. Contracts with other payors providing for negotiated rates or discounts from billed charges; and

xii. Evidence that the appealed rates jeopardize the long term financial viability of the hospital (that is, that the hospital is sustaining a marginal loss in treating Medicaid recipients) and that the hospital is necessary to provide access to care for Medicaid recipients.

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

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

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).
Amended by R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).
Added (b)2, inserted provisions defining marginal loss and incremental costs; and in (d), inserted provision providing time period for an administrative hearing request.
Amended by R.1997 d.541 effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).

Case Notes

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

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

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

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

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

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

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

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

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

SUBCHAPTER 10. CHARITY CARE

Authority

N.J.S.A. 30:4D–6a(1), 30:4D–7, 7a, b, and c; 30:4D–12, P.L.1992, c. 160; N.J.S.A. 26:2H–5 and 13.

Source and Effective Date

R.1995 d. 258, effective May 15, 1995.
See: 27 N.J.R. 656(a), 27 N.J.R. 1995(a).

10:52–10.1 Charity care audit functions

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

(b) The Department of Health shall make a monthly report to the Essential Health Services Commission on charity care. This report shall include any adjustments made pursuant to N.J.A.C. 10:52–10.14 or approvals made pursuant to N.J.A.C. 10:52–10.8(c) and (d).

10:52–10.2 Sampling methodology

(a) The Department of Health shall audit charity care claims based on a sample which will be developed in the following way:

1. Hospitals shall maintain their charity care list in a way that will allow the Department of Health to select unduplicated accounts for unit dollar sampling on a quarterly basis. The unit dollar sampling method used to select the accounts for audit is explained in the "Handbook of Sampling for Audit and Accounting" (3d edition), by Herbert Arkin. The list shall include patient name, account number, write-off date, and write-off amount.

Hospitals shall rank all charity care accounts from the smallest to the largest, based on the rate that Medicaid would have paid for each account, and run a cumulative dollar balance on the list. For 1995, a hospital may report accounts either at the Medicaid rate or gross charges provided that the reporting is done consistently throughout the year.

2. Once the selection of sample dollars has been completed and the associated patient accounts have been identified, hospitals will be required to retrieve the patient account files according to the following schedule:

Number of files to be retrieved	Time to retrieve
0–500 files	One week
501–1100 files	Two weeks
1101–1800 files	Three weeks
1801 files and above	Four weeks

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

(c) The hospital shall provide the audit list to the Department of Health no later than 30 days from the request date. If the hospital does not submit its audit list to the Department by the 30 day deadline, the Department shall assess a penalty of $2,500 per day for each day after the deadline.

10:52–10.3 Charity care write off amount

(a) The Department of Health shall value charity care claims at the Medicaid rate by multiplying the hospital's actual charity care service charges by the hospital-specific ratio of Medicaid payments to hospital charges. For write-off and billing purposes, the hospital shall use the following procedures:

1. Charity Care Write Off Amount equals Charity Care Eligibility Percentage, as determined by N.J.A.C. 10:52–10.7(b)–(c), multiplied by the Medicaid payment rate.

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

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

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

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

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

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

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

10:52–10.4 Charity care screening and documentation requirements

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

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this section through N.J.A.C. 10:52–10.9. The applicant's financial file for audit shall contain the completed charity care application in a format approved by the Essential Health Services Commission, as well as the supporting documentation which led to the determination of eligibility. For purposes of the audit, the hospital shall include in or with the file all other information necessary to demonstrate compliance with any of the audit steps.

(c) The hospital shall ask the applicant if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers compensation policy. If the applicant claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified, or the reason why the coverage could not be verified. Verification of insurance shall include the hospital contacting the identified third party insurer. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

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

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

i. May bill the applicant, consistent with the manner applied to other patients;

ii. Shall report the Medicaid value amount as charity care; and

iii. Shall report any amounts collected from the applicant or any third party as a charity care recovery.

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

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

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

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

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

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

(i) Applicants who are eligible for reimbursement under the Catastrophic Illness in Children Relief Fund shall be screened for eligibility for charity care, before referral to this Fund (see N.J.A.C. 8:18). If the applicant is not eligible for 100 percent coverage under charity care, the applicant shall be referred to the Catastrophic Illness in Children Relief Fund for the uncovered portion of the claims.

(j) Hospitals with a Federal Hill–Burton obligation at the time of the application may include applicants written-off to the Hill–Burton Program as eligible for charity care, if the applicant meets all of the eligibility standards and documentation requirements set forth in this section through N.J.A.C. 10:52–10.10.

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

(*l*) A charity care applicant may apply for charity care for services rendered per N.J.A.C. 8:31B–4.38 on or after January 1, 1995 if he or she meets the criteria in this section through N.J.A.C. 10:52–10.9.

10:52–10.5 Identification

(a) Applicants for charity care shall provide the hospital with the following proper identification: Paragraph 3 below represents an alternative measure for documenting identification as described in N.J.A.C. 10:52–10.10.

1. The applicant shall provide the hospital with one of the following identification documents: driver's license, social security card, alien registry card, birth certificate, passport, visa, death certificate, employee identification, or an attestation that the person is homeless and does not possess any of the above mentioned identification documents. If the documents listed above are not available to the applicant, the hospital staff shall document why the applicant was unable to comply, and shall ask for one of the identification documents listed in (a)2 below. If the applicant is unable to comply for medical reasons, such as, if the applicant is deceased, or noncommunicative until discharge for medical reasons, and a person to identify the patient cannot be found, the requirement for identification shall be waived.

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

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

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

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

10:52–10.6 New Jersey residency

(a) Applicants for charity care shall provide the hospital with proof of New Jersey residency. An applicant shall provide proof that he or she has been residing in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. Paragraph (a)3 below represents an alternative measure for documenting proof of residency as described in N.J.A.C. 10:52–10.11.

1. The applicant shall provide the hospital with any of the identification documents listed in N.J.A.C. 10:52–10.5(a)1 which contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. The hospital may accept an attestation from the applicant that he or she is homeless. If the applicant is unable to provide one of the documents listed above, the hospital staff shall document why the applicant was unable to comply, and shall ask for proof of residency as described in (a)2 below.

2. The applicant shall provide the hospital with any of the identification listed in N.J.A.C. 10:52–10.5(a)2 which contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State; or the applicant shall supply a copy of any undated identification listed in (a)1 and this paragraph, or any mail received showing the applicant's name and current residence address, and an attestation that the applicant has resided in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in New Jersey; or the applicant shall supply a letter from a New Jersey resident with whom the applicant is living stating that the applicant is residing with him or her. If the applicant is unable to provide one of these documents, the hospital staff shall document why the applicant was unable to comply and ask for proof of residency as described in (a)3 below.

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

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

10:52–10.7 Income eligibility criteria and documentation

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

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

1. A person whose individual or, if applicable, family income, as determined by (e) below, is less than or equal to 200 percent of the HHS Poverty Guidelines shall be eligible for charity care for necessary health services without cost.

2. A person whose individual or, if applicable, family, income as determined by (e) below, is greater than 200 percent of the HHS Poverty Guidelines but not more than 300 percent of these guidelines is eligible for charity care at a reduced rate as described in (c) below.

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

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

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

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

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

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

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

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

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

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

10:52–10.8 Proof of income

(a) Applicants for charity care shall provide the hospital with proof of income as listed below. N.J.A.C. 10:52–10.8(a)3 below shall be considered alternative documentation, as described in N.J.A.C. 10:52–10.10 above.

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

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

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

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

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

3. An applicant may document his or her income by providing an attestation which states the income received in one of the time periods described in N.J.A.C. 10:52–10.7(e)1 through 3.

(b) Family income that must be considered for the eligibility determination includes the income of all members for whom the applicant is legally responsible including, but not limited to, a spouse and any minor children for an adult. For a minor applicant, the income of the family, as determined by N.J.A.C. 10:52–10.7(a), will be considered. In situations where a minor applicant's parents are divorced, and the custodial parent(s) are remarried, the nonparental spouse's income shall be considered. In situations where both divorced parents have responsibility for the minor applicant's medical care, each parent shall complete a charity care application. For a minor applicant, the income of the family shall be considered, except for earned income of the minor child and siblings. In cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available by the following steps in (c) below.

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

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

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

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

(d) If an applicant is separated, but not legally divorced, from his or her spouse, the applicant may document that he or she has no financial ties with the estranged spouse in accordance with (d)1 through 4 below, and the hospital may waive the requirement for the estranged spouse's income, after the case is reviewed by the Department of Health, if documentation has been provided in accordance with the following:

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

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

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

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

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

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

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

10:52–10.9 Assets eligibility criteria

(a) An applicant shall provide proof that:

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

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

(b) Family members whose assets must be considered are all legally responsible individuals as defined in N.J.A.C. 10:52–10.7(a).

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

(d) The applicant shall document the value of all applicable assets as described in (d)1 through 3 below. Paragraph (d)3 below represents alternative documentation as described in N.J.A.C. 10:52–10.10.

1. The applicant shall present the hospital with a statement from a bank or other applicable financial insti-

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

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

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

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

10:52–10.10 Limit on accounts with alternative documentation

The total of all sample dollars in which identification, New Jersey residency, income, and assets documented by the alternative procedures described in N.J.A.C. 10:52–10.5(a)3, 10.6(a)3, 10.8(a)3 or 10.9(d)3 shall be limited to no more than 10 percent of the total dollars sampled on audit. Sample dollars that exceed 10 percent on the expanded sample shall be adjusted in accordance with N.J.A.C. 10:52–10.14(b) below.

10:52–10.11 Additional information to be supplied to facility by applicant

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

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

10:52–10.12 Application and determination

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

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

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

1. The date on which the eligibility determination was made;

2. The date on which hospital services were requested;

3. The date on which the services were or will be provided to the applicant;

4. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;

5. The applicant's family size, income and eligibility computation;

6. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old; and

7. The name and telephone number of a person a hospital can contact to verify eligibility pursuant to N.J.A.C. 10:52–10.8(b).

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

10:52–10.13 Collection procedures and prohibited action

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

10:52–10.14 Adjustment methodology

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

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

(c) For a compliance adjustment, each file reviewed must pass the compliance steps in N.J.A.C. 10:52–10.4 through 10.10. Failure in any one step fails the file and associated sample dollars. A failure rate (failed dollars divided by the total dollars sampled) that meets or exceeds 10 percent shall require an adjustment to the hospital's charity care listing total, based on unit dollar sampling.

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

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

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

SUBCHAPTER 10A. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

Authority

N.J.S.A. 30:4D–6a(1), (2); 30:4D–7, 7a, b, and c; and N.J.S.A. 30:4D–12; N.J.S.A. 26:2H–18.55; N.J.S.A. 26:2H–18.15; Section 1923 of the Social Security Act; and Section 5 of P.L. 1992, c.160.

Source and Effective Date

R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

10:52–10A.1 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund

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

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

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

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

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

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

1. The charity care statement is the provider's account statement for all charity care claims entered into the charity care claims pricing system. Charity care claims

shall be priced monthly and provider charity care statements shall be processed once each month.

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

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

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

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

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

10:52–10A.2 Basis of pricing for charity care claims

(a) All hospital outpatient and inpatient charity care claims shall be priced based on the New Jersey Medicaid program's pricing and program policies for hospital outpatient and inpatient hospital services. (See this chapter, and, specifically, N.J.A.C. 10:52–1.5, Covered services (outpatient and inpatient services) and N.J.A.C. 10:52–4, Basis of Payment.)

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

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

SUBCHAPTER 11. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

10:52–11.1 Introduction

(a) The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physician's Current Procedural Terminology—4th Edition (CPT–4) architecture, employing a five-position code and as many as two 2–position modifiers. Unlike the CPT–4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. LEVEL I CODES (Narratives found in CPT–4)

These codes are adapted from CPT–4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse–Midwives, Independent Clinics and Independent Laboratories. CPT–4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

Copyright restrictions make it impossible to print excerpts from CPT–4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT–4, which is incorporated herein by reference, as amended and supplemented.

2. LEVEL II CODES (Narratives found at N.J.A.C. 10:52–10.3)

These codes are assigned by HCFA for physicians and non-physician services which are not in CPT–4.

3. LEVEL III CODES (Narratives found at N.J.A.C. 10:52–4.3)

These codes are assigned by the Division to be used for those services not identified by CPT–4 codes or HCFA assigned codes. Level III codes identify services unique to New Jersey.

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

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

Column Title	Description
IND	(Indicator–Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used. Explanation of indicators and qualifiers used in this column are identified below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. "F" preceding any procedure code indicates that this code, when used primarily for the diagnosis and treatment of infertility, is not covered by the New Jersey Medicaid program. "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:52–10.3. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:52–10.4.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes are listed at N.J.A.C. 10:52–10.5.
DESCRIPTION	Lists the code narrative. (Narratives for Level I codes are found in CPT–4. Narratives for Level II and Level III codes are found at N.J.A.C. 10:52–10.3.)
MAXIMUM FEE ALLOWANCE	Lists New Jersey Medicaid program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "S.C.C." (Subject Cost-to-Charge) are listed instead of a dollar amount, it means that service is subject to the cost-to-charge ratio. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable. 1. The fee listed under "Office Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts. 2. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp" and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

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

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

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

10:52–11.2 HCPCS Procedure Codes and Maximum Fee Allowance Schedule for Pathology/Laboratory

			Maximum Fee Allowance	
Ind	HCPCS Code	Mod	Office Total Fee	$ Prof. Comp
N	36415		1.80	
N	80002		5.00	
N	80003		5.90	
N	80004		5.90	
N	80005		5.90	
N	80006		5.90	
N	80007		7.10	
N	80008		7.10	
N	80009		7.10	
N	80010		7.50	
N	80011		7.50	
N	80012		7.50	
N	80016		7.50	
N	80018		11.00	
N	80019		11.00	
N	80050		36.00	
N	80055		15.00	
N	80058		5.90	
N	80059		30.00	
N	80061		15.00	
N	80072		12.00	
N	80090		28.80	
N	80091		12.00	
	80092		37.00	
	80100		5.20	
	80101		5.20	
	80102		15.00	
	80150		15.00	
	80152		15.00	
	80154		21.50	
	80156		20.00	
	80158		20.00	
	80160		15.00	
	80162		15.00	
	80164		10.00	
	80166		15.00	
	80168		24.50	
	80170		12.60	
	80172		1.80	
	80174		15.00	
	80176		18.00	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	80178		9.00	
	80182		12.00	
	80184		12.80	
	80185		19.00	
	80186		19.00	
	80188		20.00	
	80190		15.00	
	80192		15.00	
	80194		15.00	
	80196		7.00	
	80198		15.00	
	80200		12.60	
	80202		12.00	
	80299		10.80	
	80400		34.00	
	80402		96.00	
	80406		98.00	
	80408		130.00	
	80410		127.00	
	80412		S.C.C.	
	80414		61.00	
	80415		50.00	
	80418		S.C.C.	
	80420		74.00	
	80422		45.00	
	80424		33.00	
	80426		130.00	
	80428		60.00	
	80430		73.00	
	80432		125.00	
	80434		100.00	
	80435		95.00	
	80436		75.00	
	80438		50.00	
	80439		100.00	
	80440		60.00	
	80500		9.00	
	80502		13.00	
	81000		1.20	
	81002		1.00	
	81003		1.50	
	81005		1.00	
	81007		3.82	
	81015		.40	
	81025		3.00	
	81050		3.40	
	82000		15.00	
	82003		26.00	
	82009		5.00	
	82010		10.00	
	82013		14.00	
	82024		30.00	
	82030		34.00	
A	82040		1.80	
	82042		4.30	
	82043		4.30	
	82044		1.00	
	82055		4.50	
	82075		8.80	
	82085		13.75	
	82088		40.00	
	82101		16.30	
	82103		7.80	
	82104		7.80	
	82105		10.20	
	82106		10.20	
	82108		38.00	
	82128		12.90	
	82130		25.00	
	82131		24.00	
	82135		20.00	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	82140		6.00	
	82143		4.20	
	82145		12.00	
A	82150		4.50	
	82154		40.00	
	82157		29.00	
	82160		38.00	
	82163		21.00	
	82164		20.00	
	82172		20.00	
	82175		7.20	
	82180		3.60	
	82190		S.C.C.	
	82205		12.00	
	82232		24.50	
	82239		20.00	
	82240		5.69	
A	82250		3.00	
A	82251		4.50	
	82252		2.50	
	82270		1.20	
	82273		3.70	
	82286		7.60	
	82300		30.00	
	82306		30.00	
	82307		25.00	
	82308		34.00	
A	82310		3.00	
	82330		14.70	
	82331		7.50	
	82340		3.60	
	82355		9.00	
	82360		12.00	
	82365		9.00	
	82370		9.00	
A	82374		3.30	
	82375		6.00	
	82376		3.00	
	82378		22.40	
	82380		6.00	
	82382		12.00	
	82383		12.00	
	82384		18.00	
	82387		24.00	
	82390		6.00	
	82397		21.00	
	82415		18.50	
A	82435		3.00	
	82436		3.00	
	82438		3.00	
	82441		8.92	
A	82465		3.00	
	82480		4.50	
	82482		11.27	
	82485		30.00	
	82486		4.40	
N	82487		4.00	
N	82488		15.00	
N	82489		15.00	
	82491		21.50	
	82495		30.00	
	82507		40.00	
	82520		17.00	
	82525		9.00	
	82528		19.70	
	82530		17.00	
	82533		17.00	
	82540		3.00	
A	82550		4.80	
	82552		7.80	
	82553		7.50	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	82554		16.00	
A	82565		3.00	
	82570		3.00	
	82575		4.50	
	82585		6.30	
	82595		1.50	
	82600		27.50	
	82607		15.00	
	82608		15.00	
	82615		11.50	
	82626		37.00	
	82627		33.00	
	82633		43.50	
	82634		39.00	
	82638		18.00	
	82646		25.30	
	82649		31.00	
	82651		33.00	
	82652		55.00	
	82654		13.60	
	82664		13.60	
	82666		22.00	
	82668		17.50	
	82670		25.00	
	82671		41.00	
	82672		25.00	
	82677		28.00	
	82679		25.00	
	82690		25.00	
	82693		12.50	
	82696		22.00	
	82705		.60	
	82710		7.80	
	82715		7.80	
	82725		15.50	
N	82728		16.00	
	82735		24.00	
	82742		29.50	
	82746		10.50	
	82747		18.00	
	82757		25.00	
	82759		11.50	
	82760		15.00	
	82775		30.00	
	82776		8.90	
	82784		11.30	
	82785		16.00	
	82787		49.00	
	82800		5.20	
	82803		16.50	
	82805		8.00	
	82810		10.00	
	82820		14.92	
	82926		6.00	
	82928		6.00	
	82938		26.00	
	82941		16.00	
	82943		20.00	
	82946		13.00	
A	82947		3.00	
	82948		1.50	
	82950		3.00	
	82951		5.00	
	82952		1.00	
	82953		10.00	
	82955		6.00	
	82960		7.00	
	82962		2.60	
	82963		26.50	
	82965		6.30	
	82975		22.00	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
A	82977		4.80	
	82978		12.00	
	82979		10.00	
	82980		20.00	
	82985		6.60	
	83001		17.00	
	83002		17.00	
	83003		16.00	
	83008		24.00	
	83010		12.00	
	83012		12.00	
	83015		10.20	
	83018		25.00	
	83020		6.00	
	83026		2.00	
	83030		12.00	
	83033		7.00	
	83036		6.60	
	83045		1.50	
	83050		3.00	
	83051		1.20	
	83055		1.50	
	83060		3.00	
	83065		3.00	
	83068		3.00	
	83069		3.00	
	83070		6.00	
	83071		10.00	
	83088		40.00	
	83150		12.00	
	83491		12.60	
	83497		6.00	
	83498		30.50	
	83499		30.50	
	83500		34.00	
	83505		40.00	
	83518		8.00	
	83519		15.00	
	83520		S.C.C.	
	83525		12.00	
	83527		22.00	
	83528		20.00	
A	83540		4.50	
A	83550		7.20	
	83570		6.00	
	83582		6.00	
	83586		7.50	
	83593		6.00	
	83605		15.00	
A	83615		4.20	
	83625		9.00	
	83632		16.00	
	83633		6.30	
	83634		14.00	
N	83655		9.00	
	83661		10.50	
	83662		5.00	
	83670		2.10	
	83690		4.50	
	83715		7.50	
	83717		22.00	
A	83718		8.00	
	83719		17.00	
	83721		10.00	
	83727		17.00	
A	83735		4.50	
	83775		5.90	
	83785		35.00	
	83805		26.00	
	83825		8.40	
	83835		10.20	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	83840		4.50	
	83857		12.00	
	83858		22.00	
	83864		13.00	
	83866		15.00	
	83872		3.20	
	83873		25.00	
	83874		12.00	
	83883		S.C.C.	
	83885		19.00	
	83887		20.00	
	83890		5.71	
	83892		5.71	
	83894		5.71	
	83896		5.71	
	83898		30.00	
	83912		31.39	
	83915		6.00	
	83916		20.00	
	83918		19.00	
	83925		22.00	
	83930		9.50	
	83935		9.90	
	83957		65.00	
	83945		17.00	
	83970		54.00	
	83986		4.30	
	83992		18.00	
	84022		20.00	
	84030		6.00	
	84035		4.90	
	84060		3.60	
	84061		3.60	
	84066		14.00	
A	84075		3.60	
	84078		3.60	
	84080		3.60	
N	84081		24.00	
	84085		7.90	
	84087		15.00	
A	84100		3.00	
	84105		3.00	
	84106		1.80	
	84110		7.50	
	84119		3.00	
	84120		7.50	
	84126		37.00	
	84127		15.00	
A	84132		3.90	
	84133		3.90	
	84134		20.00	
	84135		12.00	
	84138		12.00	
	84140		50.00	
	84143		60.00	
	84144		20.00	
	84146		20.00	
	84150		30.00	
	84153		26.00	
A	84155		1.80	
	84160		1.80	
	84165		6.00	
	84181		25.00	
	84182		26.00	
N	84202		10.40	
N	84203		3.00	
	84206		19.00	
	84207		40.00	
	84210		16.00	
	84220		13.00	
	84228		17.00	
	84233		16.00	
	84234		20.00	
	84235		63.20	
	84238		43.00	
	84244		25.00	
	84252		30.00	
	84255		37.00	
	84260		44.00	
	84270		25.00	
	84275		16.00	
	84285		28.80	
A	84295		3.90	
	84300		3.90	
	84305		16.00	
	84307		16.00	
	84311		7.50	
	84315		3.00	
	84375		29.00	
	84392		7.00	
	84402		38.00	
	84403		32.00	
	84425		32.00	
	84430		3.60	
	84432		13.00	
	84436		6.00	
	84437		6.00	
	84439		10.00	
	84442		12.00	
	84443		24.00	
	84445		27.80	
	84446		19.00	
	84449		30.00	
A	84450		3.00	
A	84460		3.00	
	84466		19.00	
A	84478		8.30	
	84479		6.00	
	84480		15.00	
	84481		15.00	
	84482		15.00	
	84485		3.30	
	84488		3.30	
	84490		3.30	
	84510		12.70	
A	84520		3.00	
	84525		3.00	
	84540		3.00	
	84545		6.00	
A	84550		3.00	
	84560		3.00	
	84577		6.00	
	84578		.40	
	84580		2.10	
	84583		2.10	
	84585		12.00	
	84586		50.00	
	84588		49.50	
	84590		6.00	
	84597		20.00	
	84600		18.00	
N	84620		16.00	
	84630		16.00	
	84681		22.00	
	84702		11.39	
	84703		3.00	
	84830		3.00	
	84999		S.C.C.	
	85002		1.20	
N	85007		2.40	
	85008		1.20	
	85009		1.20	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	85013		1.50	
N	85014		1.50	
N	85018		1.20	
N	85021		1.80	
N	85022		3.00	
N	85023		S.C.C.	
N	85024		4.80	
N	85025		S.C.C.	
N	85027		4.80	
	85029		2.75	
	85030		3.25	
	85031		3.00	
N	85041		1.20	
N	85044		3.00	
	85045		4.00	
N	85048		1.20	
	85060		S.C.C.	
	85095		S.C.C.	
	85097		S.C.C.	
	85102		S.C.C.	
	85130		S.C.C.	
	85170		.60	
	85175		3.90	
	85210		3.00	
	85220		25.00	
	85230		25.00	
	85240		25.00	
	85244		29.00	
	85246		10.00	
	85247		10.00	
	85250		27.00	
	85260		26.00	
	85270		26.00	
	85280		26.00	
	85290		8.00	
	85291		7.00	
	85292		28.00	
	85293		28.00	
	85300		15.00	
	85301		16.00	
	85302		17.00	
	85303		18.00	
	85305		17.00	
	85306		18.00	
	85335		10.00	
	85337		10.00	
	85345		1.80	
	85347		3.00	
	85348		1.20	
	85360		12.00	
	85362		3.00	
	85366		8.00	
	85370		5.00	
	85378		5.00	
	85379		5.00	
	85384		9.60	
	85385		9.60	
	85390		7.00	
	85400		9.00	
	85410		9.00	
	85415		10.00	
	85420		9.00	
	85421		15.00	
	85441		6.00	
	85445		5.00	
	85460		9.40	
	85475		10.00	
	85520		19.00	
	85525		17.00	
	85530		16.00	
	85535		3.00	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	85540		8.90	
	85547		10.50	
	85549		28.00	
	85555		4.80	
	85557		4.80	
	85576		10.00	
	85585		1.00	
N	85590		3.00	
N	85595		3.00	
	85597		20.00	
	85610		3.00	
	85611		4.50	
	85612		13.00	
	85613		10.00	
	85635		8.40	
	85651		1.50	
	85660		3.00	
	85670		6.60	
	85675		6.42	
	85705		7.90	
	85730		3.00	
	85732		3.00	
	85810		15.00	
	85999		S.C.C.	
	86000		.90	
	86003		20.00	
	86005		5.00	
	86021		9.00	
	86022		9.00	
	86023		15.00	
	86038		7.80	
	86039		15.00	
	86060		3.60	
	86063		1.20	
	86077		S.C.C.	
	86078		S.C.C.	
	86079		S.C.C.	
	86140		3.00	
	86147		38.00	
	86155		14.00	
	86156		3.00	
	86157		9.00	
	86160		9.00	
	86161		9.00	
	86162		15.60	
	86171		4.50	
	86185		7.90	
	86215		18.50	
	86225		13.00	
	86226		15.00	
	86235		25.00	
	86243		15.90	
	86255		7.80	
	86256		12.50	
	86277		16.00	
	86280		5.40	
	86287		10.00	
	86289		15.00	
	86290		18.00	
	86291		15.00	
	86293		12.00	
	86295		12.00	
	86296		10.00	
	86299		12.60	
	86302		19.00	
	86306		20.00	
	86308		3.00	
	86309		5.00	
	86310		4.50	
	86311		26.00	
	86316		30.00	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	86317		8.00	
	86318		7.00	
	86320		10.50	
	86325		25.00	
	86327		25.00	
	86329		20.00	
	86331		4.50	
	86332		33.00	
	86334		31.20	
	86337		13.71	
	86340		20.00	
	86341		25.00	
	86343		6.00	
	86344		10.86	
	86353		32.00	EACH MITOGEN
	86359		40.00	
	86360		55.00	
	86376		6.60	
	86378		26.00	
	86382		20.00	
	86384		10.86	
	86403		8.00	
	86430		1.80	
	86431		4.50	
	86485		S.C.C.	
	86490		S.C.C.	
	86510		S.C.C.	
	86580		S.C.C.	
	86585		S.C.C.	
	86586		S.C.C.	
	86588		13.20	
	86590		8.00	
	86592		1.50	
	86593		3.00	
	86602		10.00	
	86603		10.00	
	86606		10.00	
	86609		10.00	
	86612		10.00	
	86615		10.00	
	86618		25.00	
	86619		10.00	
	86622		8.00	
	86625		10.00	
	86628		10.00	
	86631		10.00	
	86632		15.00	
	86635		10.00	
	86638		12.50	
	86641		12.50	
	86644		23.00	
	86645		12.00	
	86648		18.00	
	86651		12.00	
	86652		12.00	
	86653		12.00	
	86654		12.00	
	86658		12.00	
	86663		12.00	
	86664		23.00	
	86665		25.00	
	86668		12.00	
	86671		15.00	
	86674		S.C.C.	
	86677		12.00	
	86682		12.00	
	86684		15.00	
	86687		12.00	
	86688		13.00	
	86689		21.20	
	86692		20.00	
	86694		12.80	
	86695		12.80	
	86698		15.00	
	86701		13.00	
	86702		13.00	
	86703		21.00	
	86710		12.00	
	86713		20.00	
	86717		S.C.C.	
	86720		15.00	
	86723		15.00	
	86727		15.00	
	86729		12.00	
	86732		15.00	
	86735		15.00	
	86738		12.00	
	86741		12.00	
	86744		12.00	
	86747		12.00	
	86750		12.00	
	86753		12.00	
	86756		12.00	
	86759		12.00	
	86762		12.00	
	86765		10.00	
	86768		12.00	
	86771		12.00	
	86774		5.40	
	86777		12.00	
	86778		15.00	
	86781		12.00	
	86784		8.00	
	86787		12.60	
	86790		S.C.C.	
	86793		8.00	
	86800		13.00	
	86805		22.00	
	86806		22.00	
	86807		55.00	
	86808		39.00	
	86812		12.60	
	86813		19.00	
	86816		19.00	
	86817		19.00	
	86821		68.00	
	86822		50.00	
	86849		S.C.C.	
	86850		4.20	
	86860		4.20	
	86870		9.00	
	86880		5.00	
	86885		6.80	
	86886		5.00	
	86890		75.00	
	86891		75.00	
	86900		2.00	
	86901		2.00	
	86903		11.70	
	86904		11.70	
	86905		3.00	
	86906		2.00	
	86910		12.60	
	86911		5.00	
	86915		67.50	
	86920		12.00	
	86921		12.00	
	86922		12.00	
	86940		9.50	
	86941		12.50	
	86945		S.C.C.	
	86950		S.C.C.	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	86965		S.C.C.	
	86970		S.C.C.	
	86971		S.C.C.	
	86972		S.C.C.	
	86975		S.C.C.	
	86976		S.C.C.	
	86977		S.C.C.	
	86978		S.C.C.	
	86985		S.C.C.	
	86999		S.C.C.	
	87001		9.00	
	87003		15.00	
	87015		5.10	
N	87040		9.00	
N	87045		9.00	
N	87060		9.00	
N	87070		9.00	
	87072		6.00	
	87075		9.00	
	87076		6.00	
	87081		9.00	
	87082		4.00	
	87083		4.00	
	87084		3.00	
	87085		4.00	
	87086		6.00	
	87087		2.70	
	87088		2.70	
	87101		8.00	
	87102		8.00	
	87103		8.00	
	87106		8.00	
	87109		14.00	
	87110		15.00	
	87116		6.00	
	87117		9.00	
	87118		12.00	
	87140		3.00	
	87143		3.00	
	87145		3.00	
	87147		3.00	
	87151		3.00	
	87155		3.00	
	87158		3.00	
	87163		12.00	
	87164		6.00	
	87166		6.00	
	87174		10.00	
	87175		15.00	
	87176		6.40	
	87177		5.10	
	87178		24.00	
	87179		24.00	
	87181		5.80	
N	87184		9.00	
	87186		13.00	
	87187		13.00	
	87188		6.00	
	87190		.60	
	87192		.60	
	87197		15.00	
	87205		4.20	
	87206		4.20	
	87207		3.00	
	87208		5.10	
	87210		2.40	
	87211		5.10	
	87220		2.40	
	87230		27.00	
	87250		28.00	
	87252		29.50	
	87253		6.00	
	87999		S.C.C.	
	88104		S.C.C.	7.00
	88106		S.C.C.	7.00
	88107		S.C.C.	7.00
	88108		S.C.C.	7.00
	88125		S.C.C.	
	88130		9.65	7.00
	88140		4.20	3.00
	88150		6.00	
	88151		6.00	
N	88155		6.00	
	88156		6.00	
	88157		6.00	
	88160		S.C.C.	
	88161		S.C.C.	7.00
	88162		S.C.C.	
	88170		S.C.C.	
	88171		S.C.C.	
	88172		S.C.C.	
	88173		S.C.C.	
	88180		S.C.C.	
	88182		300.00	
	88199		S.C.C.	
	88230		90.00	
	88233		90.00	
	88235		90.00	
	88237		90.00	
	88239		90.00	
	88245		184.00	
	88248		230.00	
	88250		184.00	
	88262		184.00	
	88263		184.00	
	88267		230.00	
	88280		37.00	
	88283		46.00	
	88285		2.00	
	88289		40.00	
	88300		S.C.C.	7.00
	88302		S.C.C.	15.00
	88304		S.C.C.	19.00
	88305		S.C.C.	30.00
	88307		S.C.C.	44.00
	88309		S.C.C.	66.00
	88311		S.C.C.	
	88312		S.C.C.	8.00
	88313		S.C.C.	5.00
	88314		S.C.C.	7.00
	88318		S.C.C.	
	88319		S.C.C.	
	88321		S.C.C.	
	88323		S.C.C.	
	88325		S.C.C.	
	88329		S.C.C.	
	88331		S.C.C.	41.00
	88332		S.C.C.	
	88342		S.C.C.	7.00
	88346		40.00	7.00
	88347		45.00	7.00
N	88348		184.00	151.00
N	88349		S.C.C.	151.00
	88355		S.C.C.	31.50
	88356		S.C.C.	31.50
	88358		S.C.C.	31.50
	88362		S.C.C.	31.50
	88365		47.25	15.75
	88371		S.C.C.	
	88372		S.C.C.	
	88399		S.C.C.	
	89050		0.90	

Ind	HCPCS Code	Mod	Maximum Fee Allowance Office Total Fee	$ Prof. Comp
	89051		0.90	
	89060		8.50	
	89100		S.C.C.	
	89105		S.C.C.	
	89125		0.60	
	89130		S.C.C.	
	89132		S.C.C.	
	89135		S.C.C.	
	89136		S.C.C.	
	89140		S.C.C.	
	89141		S.C.C.	
	89160		2.10	
	89190		2.20	
	89300		2.40	
	89310		4.80	
	89320		3.00	
	89325		13.00	
F	89329		31.00	
F	89330		8.00	
	89350		S.C.C.	
	89355		S.C.C.	
N	89360		S.C.C.	
	89399		S.C.C.	
L	G0001		1.80	
L	P9610		1.80	
L	P9615		1.80	
L	Q0111		2.40	
L	Q0112		2.40	
L	Q0113		5.10	
L	Q0114		9.60	
L	Q0115		12.33	
L	Q0116		2.00	
LN	W8200		2.00	
L	W8260		33.00	
L	W8265		33.00	
L	W8730		11.00	
L	W8900		10.00	
L	W8920		1.80	
L	W8925		.60	

10:52–11.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT–4)

PATHOLOGY/LABORATORY

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance
	G0001		Routine Venipuncture QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	$ 1.80
	P9610		Catheterization for collection of (urine) specimen(s), single home bound, nursing home, or SNF patient QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	1.80
	P9615		Catheterization for collection of (urine) specimen(s), (multiple) patients QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	1.80
	Q0111		Wet mount, including preparations of vaginal, cervical or skin specimens	2.40
	Q0112		All potassium hydroxide (KOH) preparations	2.40
	Q0113		Pinworm examination	5.10
	Q0114		Fern test	9.60
	Q0115		Post-coital direct, qualitative examinations of vaginal or cervical mucous	12.33
	Q0116		Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurements and read-out	2.00
N	W8200		Glucose, serum (separate tube, grey top) QUALIFIER: Submitted on same claim, and performed on same date as chemistry profiles	2.00
	W8260		Haldol (haloperidol) serum, confirmation test	33.00
	W8265		Serentil, serum mesoridazine, quantitative, confirmation test	33.00
	W8730		Gonozyme, Gonococcal antigen	11.00
	W8900		House call to home bound patient in home or sheltered boarding home for purpose of obtaining blood by venous or arterial puncture QUALIFIER: Reimbursement limited to once per trip regardless of number of patients	10.00
	W8920		Visit to obtain blood specimens by venous or arterial puncture "first person in nursing home"	1.80
	W8925		Each additional person in nursing home	.60

10:52–11.4 Pathology and Laboratory HCPCS Codes—Qualifiers

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

1. Chemistry Automated, Multichannel Tests

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

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

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

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

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

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

NOTE 4: Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional $2.00.

2. Codes 80050, 80055, 80058, 80059, 80061, 80072, 80090, 80091, 80092—The panels listed must include the laboratory tests assigned by the CPT–4 as the components of the panel. The tests listed with each of the panels identify the defined components of that panel. If any laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

NOTE 1: Code 80091—Thyroid panel

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

NOTE 2: Code 80092—Thyroid panel with TSH

Code 8443—TSH will not be paid a separate reimbursement when performed in conjunction with 80091 or 80092.

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

4. Code 82728—Ferritin

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

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

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

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

8. Codes 85023 and 85025—Hematology

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

Hematology codes 85014, 85018, 85041 and 85048 may not be billed in conjunction with codes for blood count with hemogram (85021, 85022, 85023, 85024, 85025, and 85027).

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

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

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

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

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

10. Code 88155—pap smear

NOTE: Obtaining specimen not a separate eligible service.

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

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

12. Code 89360—Sweat (without iontophoresis) test

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

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

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

10:52–11.5 Pathology and Laboratory HCPCS Codes—Modifiers

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

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

SUBCHAPTER 12. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

Authority

N.J.S.A. 30:4D–6a(1); 7, 7a, b, and c, 30:4D–12; 42 C.F.R. 447.200 through 205, 250 and 252; and P.L. 1996, c.42.

Source and Effective Date

R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

10:52–12.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed

(a) Effective for services on or after October 1, 1996, and prior to July 6, 1998, the amount of hospital reimbursement for GME and IME to be distributed shall be calculated based on Medicare principles of reimbursement to major teaching hospitals. Major teaching hospitals are defined as those hospitals which had a minimum of 45 intern and resident full-time equivalents (FTEs) in all approved and accredited residencies from the 1993 Medicare first finalized audited cost report.

(b) Medicare principles of reimbursement for GME and IME are as follows:

1. Direct GME is calculated based on Medicaid's and NJ KidCare-Plan A's fee-for-service share of the major teaching hospitals' intern and resident FTEs multiplied by their specific per resident amounts as reported on the Medicare audited cost report (including subsequent amendments) in Worksheet E–3 Part IV for the year in which payment is being made.

2. IME is calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference. The major teaching hospitals' IME factor, as calculated by the Medicare IME formula, is multiplied by their hospital-specific Medicaid and NJ KidCare-Plan A fee-for-service inpatient DRG payments (net of GME and IME) to arrive at the Medicaid and NJ KidCare-Plan A fee-for-service IME payment. The components of Medicare's IME formula, IME intern and resident FTEs and maintained beds, are from the audited Medicare cost report (including subsequent amendments) in Worksheet S–3 for the year in which payment is being made.

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), inserted "and prior to July 6, 1998," following "1996,"; and in (b), inserted references to NJ KidCare-Plan A fee-for-service throughout.

10:52–12.2 Distribution of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement

Effective for services on or after October 1, 1996, and prior to July 6, 1998, hospital reimbursement for GME and IME as calculated in N.J.A.C. 10:52–12.1, shall be distributed to all teaching hospitals based on the hospital-specific percentage of total weighted GME FTEs, where weighted GME FTEs equals the hospital-specific current GME FTEs times the hospital-specific Medicaid and NJ KidCare-Plan A fee-for-service days divided by the total Medicaid and NJ KidCare-Plan A fee-for-services days for all teaching hospitals. The source for the GME FTEs and the Medicaid and NJ KidCare-Plan A fee-for-service days is the Medicare audited cost report including subsequent amendments for the year in which payment is being made.

Amended by R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).
Inserted "and prior to July 6, 1998" following "1996,", and inserted references to NJ KidCare-Plan A fee-for-service days throughout.

10:52–12.3 Establishment of GME and IME interim method of reimbursement

Effective for services provided on or after January 21, 1997, and prior to July 6, 1998, all teaching hospitals are required to submit, for the year in which payment shall be made, their estimated average intern and resident GME and IME FTE count and maintained beds by November 1 of the preceding year to Blue Cross and Blue Shield of New Jersey (BCBSNJ), the Division's settlement agent. BCBSNJ shall review the submitted information for reasonableness and consistency and forward the information to the Division. Effective for services on or after October 1, 1996, and prior to July 6, 1998, the Division shall calculate Medicaid's and NJ KidCare-Plan A fee-for-service GME and IME payment based on the major teaching hospitals' submitted data and their Medicaid and NJ KidCare-Plan A fee-for-service inpatient DRG payments (net of IME and GME) from their most current fiscal year Unisys settlement data report with 24 months of paid data. Once the fee-for-service GME and IME payment is calculated, it shall be distributed to all teaching hospitals in accordance with N.J.A.C. 10:52–12.2 utilizing the submitted FTE count and the Medicaid and NJ KidCare-Plan A fee-for-service days from the teaching hospitals' most current fiscal year Unisys settlement data report with 24 months of paid data. The payment shall be made in equal monthly installments and reconciled in accordance with N.J.A.C. 10:52–12.4.

Amended by R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).
Inserted "and prior to July 6, 1998" in the first and third sentences, and inserted references to NJ KidCare-Plan A fee-for-service throughout.

10:52–12.4 Establishment of GME and IME final method of reimbursement

Effective for services on or after October 1, 1996 and prior to July 6, 1998, the Medicaid and NJ KidCare-Plan A fee-for-service GME and IME final payment shall be calculated in accordance with N.J.A.C. 10:52–12.1 and distributed to all teaching hospitals in accordance with N.J.A.C. 10:52–12.2. A reconciliation of the final GME and IME distribution of payment to the interim GME and IME distribution of payment shall be made and additional disbursement or recoupment shall be made in accordance with N.J.A.C. 10:52–4.7(a)1 through 5.

Amended by R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).
Inserted "and prior to July 6, 1998" and inserted a reference to NJ KidCare-Plan A fee-for-service in the first sentence.

10:52–12.5 Hospital fee-for-service reimbursement for Graduate Medical Education (GME) effective on or after July 6, 1998

(a) Effective for payments on or after July 6, 1998, the GME payment shall be distributed in 12 monthly lump sum payments during the State Fiscal Year. The amount distributed shall be considered the final GME payment and shall not be reconciled. The GME payment shall not exceed the amount appropriated for GME each State Fiscal Year. This GME payment represents both direct GME and Indirect Medical Education (IME).

(b) The source of the data used to allocate the GME payment is the most recent Medicare submitted cost report with corresponding 24–month fee-for-service Medicaid and NJ KidCare-Plan A inpatient paid claims data as of February 1 prior to the year of distribution. GME resident full-

time-equivalents and total hospital days shall come from the Medicare submitted cost report. The hospital-specific Medicaid and NJ KidCare-Plan A fee-for-service days shall come from the 24–month data fee-for-service Medicaid and NJ KidCare-Plan A inpatient paid claims data.

(c) The intern and resident full-time equivalents (FTEs) as reported on the Medicare submitted cost report may be audited by the Division of Medical Assistance and Health Services or its agent prior to payment. An adjustment, if necessary, to the submitted intern and resident FTEs shall be made in accordance with the audit.

New Rule, R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).

10:52–12.6 Distribution of Graduate Medical Education (GME) effective on or after July 6, 1998

(a) Effective for payments on or after July 6, 1998, the amount appropriated for GME shall be distributed to all eligible acute care teaching hospitals. An eligible acute care teaching hospital is defined as an acute care teaching hospital that has a combined Medicaid and NJ KidCare-Plan A fee-for-service utilization at or above the median of all New Jersey acute care hospitals. The Medicaid and NJ KidCare-Plan A fee-for-service utilization is calculated using the hospital-specific Medicaid and NJ KidCare-Plan A fee-for-service days divided by the hospital-specific total days.

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

1. The combined GME and Hospital Relief Subsidy Fund (HRSF) for each eligible acute care teaching hospital which receives a direct State appropriation shall be contained at its calendar year 1997 HRSF plus its calendar year 1997 interim GME/IME payment. The balance shall be distributed proportionately to the remaining qualifying GME hospitals.

New Rule, R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).

APPENDIX

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 pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

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