

CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

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

Source and Effective Date

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

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 52, Hospital Services Manual, expires on December 7, 2010. See: 42 N.J.R. 1656(a).

Chapter Historical Note

Chapter 52, Manual for Hospital Services, was adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c).

Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1, Coverage, was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b).

Pursuant to Executive Order No. 66(1978), Subchapter 2, Admissions and Billing Procedures, was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1992 d.327, effective August 17, 1992, operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a).

Subchapter 5, Procedural and Methodological Regulations, Subchapter 6, Financial Reporting Principles and Concepts, Subchapter 7, Diagnosis Related Groups (DRG), Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993, to expire May 10, 1993. See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 1582(a), 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Manual for Hospital Services, was readopted as R.1995 d.123, effective February 3, 1995. As a part of R.1995 d.123, Chapter 52 was renamed Hospital Services Manual, and Subchapter 1, Coverage, Subchapter 2, Admission and Billing Procedures, Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric Services, Subchapter 4, Basis of Payment for Hospital Services, and Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, were adopted as new rules, effective April 17, 1995. See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Subchapter 10, Charity Care, was adopted as R.1995 d.258, effective May 15, 1995. See: 27 N.J.R. 656(a), 27 N.J.R. 1995(a).

Subchapter 12, Graduate Medical Education and Indirect Medical Education, was adopted as R.1997 d.43, effective January 21, 1997. See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was adopted as R.1997 d.520, effective January 5, 1998. See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

Pursuant to Executive Order No. 66(1978), Chapter 52, Hospital Services Manual, was readopted as R.2000 d.29, effective December 21, 1999, and Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, was recodified as Subchapter 13, Eligibility for and Basis of Payment for Disproportionate Share Hospitals, Subchapter 10, Charity Care, was recodified as Subchapter 11, Charity Care, Subchapter 10A, Charity Care Component of the Disproportionate Share Hospital Subsidies, was recodified as Subchapter 12, Charity Care Component of the Disproportionate Share Hospital Subsidies, Subchapter 11, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, was recodified as Subchapter 10, HCFA Common Procedure Coding System (HCPCS) for Hospital Outpatient Laboratory Services, and Subchapter 12, Graduate Medical Education and Indirect Medical Education, was recodified as Subchapter 8, Graduate Medical Education and Indirect Medical Education, by R.2000 d.29, effective January 18, 2000. See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

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

Subchapter 14, Methodology for Establishing DRG Payment Rates for Inpatient Services at General Acute Care Hospitals Based on DRG Weights and a Statewide Base Rate, was adopted as new rules by R.2009 d.249, effective August 3, 2009. See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

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APPENDIX A. FISCAL AGENT BILLING SUPPLEMENT

APPENDIX B. EMC MANUAL

SUBCHAPTER 1. GENERAL PROVISIONS

10:52-1.1 Purpose and scope

(a) This chapter outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid and NJ FamilyCare fee-for service beneficiaries. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and psychiatric hospitals, unless specifically indicated otherwise.

(b) Unless otherwise stated, the rules of this chapter apply to Medicaid and NJ FamilyCare fee-for-service beneficiaries and to Medicaid and NJ FamilyCare fee-for-service services which are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services which are to be provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO in accordance with the Division's rules for MCOs at N.J.A.C. 10:74, the MCO's policies and procedures, and the MCO's provider contract with the State, and all amendments thereto.

Petition for Rulemaking.

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

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

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

In (a), substituted a reference to Medicaid and NJ KidCare fee-for service beneficiaries for a reference to Medicaid recipients, and substituted a reference to psychiatric hospitals for a reference to private psychiatric hospitals; and added (b).

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

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

In (a), substituted "FamilyCare" for "KidCare"; rewrote (b).

10:52-1.2 Definitions

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

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

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

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

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

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

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

"DHSS" means the State Department of Health and Senior Services.

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

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

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

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

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid and NJ FamilyCare-Children's Program-Plan A beneficiaries under 21 years of age for the purpose of assessing a beneficiary's health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

"Entity," as used in N.J.A.C. 10:52-1.3, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

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

"Financial Elements" means the reasonable cost of items approved as reimbursable under Medicaid (see N.J.A.C. 10:52-5.9).

"Group outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders which involves a group of usually four to 12 beneficiaries who have similar

problems and treatment needs. The group meets regularly with a therapist who uses the interaction of the group members to relieve distressful symptoms and modify beneficiaries' behavior.

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

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

“Hospital” means, pursuant to section 1861(e) of the Social Security Act (42 U.S.C. § 1395x(e)), an institution which meets the following requirements:

1. Is primarily engaged in providing diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or rehabilitation services for the rehabil-

itation of injured, disabled, or sick persons or is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons;

2. Maintains clinical records on all patients;
3. Has by-laws in effect with respect to its staff of physicians;
4. Requires every patient to be under the care of a physician;
5. 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;
6. 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;
7. 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;

8. 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

9. For the purposes of N.J.A.C. 10:52-1.3 only, is where the main inpatient hospital services are located.

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

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid/NJ FamilyCare provider);
2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act);
3. Has in effect a hospital utilization review plan applicable to all patients who received medical assistance under Medicaid (Title XIX) and NJ FamilyCare-Children’s Program (Title XXI); and
4. Has signed a provider agreement to participate in and abide by Federal and State laws and 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 Federal and State laws and 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 and Senior Services 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 is approved to participate as a provider in the Division if it meets the appropriate standards of participation for either a Special (Acute care or short term) or a Comprehensive Rehabilitation Hospital and:

1. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health and Senior Services;
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
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 Federal and State laws and regulations.

“Individual outpatient hospital psychiatric services” means an outpatient therapy for mental health disorders that is tai-

lored for a beneficiary and is administered one on one, in sessions which last between 30 minutes and one hour and which are provided on a regular basis for a defined period of time.

“Individual outpatient hospital psychiatric services for youth or young adults” means an outpatient therapeutic intervention that is provided directly to or on behalf of an individual youth or young adult, which may last between 30 minutes to one and a half hours and is provided on a regular basis as part of an integrated plan of service that may be supported by other strategies, interventions, and supports in the community. Such interventions may include family conferencing or family counseling with the purpose of the intervention to support a plan of treatment for the youth or young adult.

“Inliers” means inpatient cases which 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, dentist or nurse midwife 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.

“Medical social worker” means an individual who is licensed or certified in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G and meets the Medicare certification requirements for education (See 42 U.S.C. § 1395x).

“Medication management” means medication services to evaluate, prescribe or administer and monitor a beneficiary’s use of psychotropic medications provided by, or under the supervision of, a licensed physician or APN.

“Medication management for youth or young adults” means therapeutic services provided by a qualified medical/mental health professional who, within the scope of their practice, evaluates, prescribes, administers, or monitors the use of therapeutic medications to assist in improving the ability of a youth or young adult to function in the community with, primarily, such therapeutic medications addressing the mental/behavioral health challenges of the youth or young adult. This service also includes providing education to the youth or young adult and their family/caregiver, as appropriate, about the benefits, side effects, and potential impact of the medications on the physical/mental health of the youth or young adult.

“Medication monitoring” means medication services provided to monitor a beneficiary’s use of psychotropic medications under the supervision of a licensed physician or APN.

“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, therapeutic, 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 a psychiatric hospital or an excluded unit of a general hospital and the

institution is licensed or formally approved as a hospital by the New Jersey State 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 XVIII) as a hospital; and meets the criteria for participation as stated in N.J.A.C. 10:52-1.3.

“Partial hospital” or “PH” means an individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

“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.

“State fiscal year” means the State of New Jersey’s fiscal year, which begins July 1 and ends the following June 30.

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

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

“Young adult” means, for purposes of outpatient mental health/psychiatric services, an individual who is at least 18 years old and under 21 years old.

“Youth” means, for purposes of outpatient mental health/psychiatric services, an individual under 18 years old.

“Youth and young adult partial hospital” means an intensive, highly structured outpatient treatment program, provided in a hospital-based setting as approved by the Division of Medical Assistance and Health Services, that provides services designed primarily for youth and young adults under age 21 and intended to minimize the need for hospitalization that meets the requirements of this chapter and all other State rules and laws regarding youth and young adult partial hospital services.

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”.

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

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

Deleted “Adjusted admissions” and “Informed Consent”; inserted “DHSS”; in “Early and Periodic Screening, Diagnosis and Treatment (EPSDT)”, substituted references to Medicaid and NJ KidCare—Plan A beneficiaries for references to Medicaid recipients, and inserted “or age 19 for NJ KidCare—Plan A beneficiaries” following “age”; in “Hospital”, inserted a reference to 42 U.S.C. § 1395x(e) in the introductory paragraph; in Hospital (Approved General), inserted references to NJ KidCare in 1 and 3; in “Hospital (Approved Special)”, made internal designation changes; in “Inpatient”, inserted a reference to nurse midwives; in “Outpatient hospital services”, substituted “a psychiatric hospital or an excluded unit of a general hospital and the institution” for “private inpatient psychiatric facility for patients under 21 and over 65 years of age; and the institution that” following “and/or by”, and changed N.J.A.C. reference; and changed “Uniform Bill—Patient Summary (UB-PS or UB-92)” definition to “Uniform Bill—Patient Summary (UB-92)”.

Amended by R.2003 d.485, effective December 15, 2003.

See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

Added “Disproportionate share hospital”.

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

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

Rewrote the section.

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

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

Added definitions “Adult acute partial hospital”, “Group outpatient hospital psychiatric services”, “Individual outpatient hospital psychiatric services”, “Medication management”, “Medication monitoring” and “Partial hospital”.

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

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

Added definitions “Clinically licensed mental health professional”, “Group outpatient hospital psychiatric services for youth or young adults”, “Individual outpatient hospital psychiatric services for youth or young adults”, “Medication management for youth or young adults”, “Young adult”, “Youth” and “Youth and young adult partial hospital”.

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 (Reserved)

Recodified to N.J.A.C. 10:52-1.3 by R.2000 d.29, effective January 18, 2000.

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

10:52-1.3 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 or NJ FamilyCare fee-for-service program as an outpatient hospital service shall have been approved by 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 or NJ FamilyCare fee-for-service programs 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.

ii. Pursuant to P.L. 2001, c.393, specialized pediatric facilities licensed to provide pediatric comprehensive rehabilitation services shall not be subject to the close proximity criterion contained in (b)1 above. However, such pediatric facilities shall be subject to all other criteria set forth in (b)2 through 8 below.

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

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 date 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 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/NJ FamilyCare fee-for-service 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
Office of Hospital Reimbursement
PO Box 712, Mail Code #44
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.

6. The Offsite Location (entity) Certification Form (FD-392) can be requested from the above address.

(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. 10:52-4.8, 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).

Recodified from N.J.A.C. 10:52-1.2A and amended by R.2000 d.29, effective January 18, 2000.

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

In (a) and (b), inserted references to NJ KidCare fee-for-service programs; and in (c)3, inserted a reference to NJ KidCare fee-for-service reimbursement. Former N.J.A.C. 10:52-1.3, Eligibility; claims procedures, recodified to N.J.A.C. 10:52-1.4.

Amended by R.2002 d.378, effective November 18, 2002.

See: 34 N.J.R. 2246(a), 34 N.J.R. 2549(b), 34 N.J.R. 3980(a).

Added (b)1ii.

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

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

In (a), substituted "FamilyCare" for KidCare" preceding "fee-for-service" and deleted "of Medical Assistance and Health Services "known as the "Division");" preceding "in accordance with this rule"; in (c), substituted "FamilyCare" for KidCare" preceding "fee-for-service" in 3, amended the address in 4 and added 6; in (d), amended the N.J.A.C. reference.

Public Notice: Moratorium on New or Relocated Hospital-Based Off-Site Clinic Services Applications.

See: 37 N.J.R. 3860(a).

Case Notes

Division's interpretation of N.J.A.C. 10:52-1.3(b)(7) to require that an offsite outpatient hospital facility entitled to hospital-level rates be located in a building that is solely for the hospital facility was arbitrary, capricious, or unreasonable and constituted improper rulemaking in violation of *Metromedia, Inc. v. Director, Div. of Taxation*, 97 N.J. 313 (1984). N.J.A.C. 10:52-1.3(b)(7) only requires that the entity be held out and appear to the public to be part of a hospital, and no regulation requires separate entrances or that the building be used solely for the hospital; signage and notices in and around the facilities, the size, layout, and the equipment in the facilities, as well as the hospital identification badges worn by the staff, sufficiently presented the entities to the public as being affiliated with the hospital. *Bacharach Physical Therapy v. DMAHS*, OAL Dkt. Nos. HMA 2363-07 and HMA 2548-07, 2007 N.J. AGEN LEXIS 814, Initial Decision (December 11, 2007).

10:52-1.4 Use of PA-1C when applying for benefits for a hospital patient

(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 children who do not qualify or who do not want an SSI money payment from the Social Security Administration and/or do want to be a Medicaid beneficiary 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 board of social services (CBOSS).

3. A hospital shall submit the form PA-1C to the county board of social services (CBOSS) 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, 3, 11a and 15 only. The mother's signature shall be included in Item 22.)

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. With the exception of mothers receiving benefits through the Emergency Services for Aliens Program, a mother who is a Medicaid beneficiary and her newborn shall have the same Medicaid Eligibility Identification Number when they are a part of the same household, but each shall be assigned his or her own Person Number. A mother receiving benefits through the Emergency Services for Aliens Program shall be assigned a Medicaid Eligibility Identification Number, and her newborn shall be assigned a separate Medicaid Eligibility Identification Number after being determined eligible in accordance with N.J.A.C. 10:69 or N.J.A.C. 10:72, as applicable.

iii. A hospital shall be permitted to submit a claim for services to a newborn of a mother not enrolled in managed care 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 CBOSS with a note of explanation (see also N.J.A.C. 10:49-2 in Administration for further information on Medicaid eligibility).

Recodified from N.J.A.C. 10:52-1.3 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted references to beneficiaries for references to recipients and substituted references to CBOSS for references to CWA throughout, and substituted a reference to Medicaid Eligibility Identification Numbers for a reference to HSP (Medicaid) Case Numbers in 3ii. Former N.J.A.C. 10:52-1.4, Eligibility of recipient for hospital services, recodified to N.J.A.C. 10:52-1.5.

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

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

In (a)3, substituted "3" for "4" and "22" for "23" in the introductory paragraph, rewrote ii and inserted "of a mother not enrolled in managed care" preceding "for 60 days" in iii.

10:52-1.5 Eligibility of beneficiary for hospital services

(a) Hospital services shall not be reimbursed by Medicaid or NJ FamilyCare fee-for-service programs when hospital services were rendered prior to or after the period of beneficiary eligibility, as determined in accordance with N.J.A.C. 10:49-2.7; except that, when a Medicaid beneficiary 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 beneficiary shall apply for retroactive eligibility, in accordance with N.J.A.C. 10:49-1.1.

Recodified from N.J.A.C. 10:52-1.4 and amended by R.2000 d.29, effective January 18, 2000.

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

Substituted references to beneficiaries for references to recipients throughout; and in (a), inserted a reference to NJ KidCare fee-for-service programs, and changed N.J.A.C. reference. Former N.J.A.C. 10:52-1.5, Covered Services (Inpatient and Outpatient), recodified to N.J.A.C. 10:52-1.6.

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

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

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service" and substituted "prior to or after the period" for "prior to and after period" preceding "of beneficiary eligibility".

10:52-1.6 Covered services (inpatient and outpatient)

(a) The Division will cover those inpatient services ordinarily furnished by an approved hospital maintained for the treatment and care of patients and provided to any Medicaid or NJ FamilyCare fee-for-service beneficiary for whom professionally developed criteria and standards of care were used to determine that the beneficiary warranted an appropriate hospital level of care for a given diagnosis 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. 10:52-1.14 and Administrative Days in N.J.A.C. 10:52-1.9.)

4. Non-physician services, supplies and equipment supplied by an outside vendor to Medicaid beneficiaries 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 beneficiary is a patient and shall not be billed directly to the Medicaid or NJ FamilyCare fiscal agent.

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

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

1. When the Utilization Review Organization (URO) denies the entire admission for acute level of care; or
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 or NJ FamilyCare fee-for-service shall be made, because the services are already included in the DRG reimbursement rate; or
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 beneficiary age 65 or older; or for any other Medicaid or NJ FamilyCare-Children's Program beneficiary before reaching the age of 21, except that a Medicaid beneficiary receiving the services immediately before attaining age 21 may continue to receive the services until they are no longer needed or until the beneficiary reaches age 22, whichever occurs first.

(d) Outpatient services include 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 certified nurse midwife services, pursuant to the rules of the Division, State 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:
 - i. Identified on the UB-92 claim form as a 131 or 136 bill type in accordance with N.J.A.C. 8:31B-3.11(a)1;
 - ii. The patient shall be discharged before midnight of the day of admission so the admission date and discharge date are the same;
 - iii. The patient shall have 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. The patient shall have 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 Same day surgery.)
3. Physician services in hospitals (that is, specifically unbundled physicians): A physician practicing in a hospi-

tal out-patient department whose reimbursement is not part of the hospital's cost may bill fee-for-service if the arrangement with the hospital permits it.

(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. 10:52-2.6 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. 10:52-2.7 and N.J.A.C. 8:86, 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. 10:52-2.4.

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

Recodified from N.J.A.C. 10:52-1.5 and amended by R.2000 d.29, effective January 18, 2000.

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

Substituted references to beneficiaries for references to recipients throughout; in (a), inserted a reference to NJ KidCare fee-for-service beneficiaries in the introductory paragraph, changed N.J.A.C. references in 3 and 5, and inserted a reference to NJ KidCare fiscal agents in 4; in (b)2, inserted a reference to NJ KidCare—Plan A, B, or C fee-for-service; in (c), inserted a reference to NJ KidCare beneficiaries; rewrote (d); and in (g) through (i), changed N.J.A.C. references. Former N.J.A.C. 10:52-1.6, Disproportionate share of adjustments, recodified to N.J.A.C. 10:52-1.7.

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

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

Rewrote the section.

10:52-1.7 Offset of disproportionate share hospital payments

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

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.

Recodified from N.J.A.C. 10:52-1.6 and amended by R.2000 d.29, effective January 18, 2000.

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

Former N.J.A.C. 10:52-1.7, Non-Covered Services (Inpatient and Outpatient), recodified to N.J.A.C. 10:52-1.8.

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

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

Rewrote the section.

10:52-1.8 Non-covered services (inpatient and outpatient)

(a) The following non-covered services (inpatient and outpatient) shall not be eligible for payment by the Division:

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 an 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 beneficiary is age 65 or over;

(2) The Medicaid beneficiary has not attained age 21, except that a beneficiary who is 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;

(3) The NJ FamilyCare-Plan A beneficiary has not attained the age of 21; or

(4) The FamilyCare-Children's Program-Plan B, C or D beneficiary has not attained the age of 19; and

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

2. Any service or item requiring prior authorization (see N.J.A.C. 10:52-1.10, 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 or surgical or medical treatment for which the patient is admitted.

iii. Inpatient hospital services rendered in a general hospital at any time following the day that such services are no longer medically necessary, except when special circumstances, that is, "social necessity," exist which prevent the discharge or transfer of the patient or when an inpatient is eligible for "administrative days" (see N.J.A.C. 10:52-1.14, Social Necessity and N.J.A.C. 10:52-1.9, 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. 10:52-1.13 Second Opinion Program);

7. Transportation, except as in N.J.A.C. 10:52-2.16—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. 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.

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

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

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

13. 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.

Recodified from N.J.A.C. 10:52-1.7 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted references to beneficiaries for references to recipients and changed N.J.A.C. references throughout, inserted 1vi(3), deleted a former 9, and recodified former 10 through 14 as 9 through 13. Former N.J.A.C. 10:52-1.8, Administrative Days (Nursing Facility Level of Care)—General, Special (Classification A & B) and Private Psychiatric Hospitals, recodified to N.J.A.C. 10:52-1.9.

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

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

In (a), rewrote the introductory paragraph, substituted "a beneficiary who is" for "an individual" preceding "receiving such services" in 1iv(2), added a new 1iv(3), recodified former 1iv(3) as 1iv(4) and rewrote the paragraph, deleted "and/" following "diagnostic services" in 3ii, rewrote 3iii and amended the N.J.A.C. reference in 7.

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).

10:52-1.9 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 is able to demonstrate the following:

1. All other possible health insurance benefits have been utilized;
2. Discharge planning was initiated upon admission of the patient to the hospital and was reviewed and updated regularly;
3. Within one working day of identifying a Medicaid or NJ FamilyCare-Plan A beneficiary as being at risk for nursing facility placement, the hospital notified the Medical Assistance Customer Center (MACC), CBOSS and the Office of Community Choice Options (OCCO). See N.J.A.C. 10:52-1.11 Preadmission screening for nursing facility placement; and

4. 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), a Preadmission Screening Evaluation (PAS) confirmed the necessity for nursing facility services and 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 require every nursing facility in the State to reserve a Medicaid beneficiary's bed for up to 10 days when the beneficiary is transferred from the nursing facility to a general or private psychiatric hospital. This requirement is applicable to NJ FamilyCare-Plan A beneficiaries also. If the discharged Medicaid or NJ FamilyCare-Plan A beneficiary is unable to return to the nursing facility before the end of the 10-day period, the discharged beneficiary shall have priority for the next available Medicaid bed in the facility. When the beneficiary 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;
2. Advise the NF of an anticipated discharge date;
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.

(d) When the 10-day bed reserve is exceeded and no bed is available in the NF from which the beneficiary was transferred, the hospital shall provide the level of NF care determined appropriate by the Department of Health and Senior Services-designated professional staff during the Preadmission Screening Evaluation until such time as a NF bed is available to the Medicaid or NJ FamilyCare-Plan A beneficiary. (See N.J.A.C. 10:52-1.11.)

(e) For the information of hospital staff assisting in the discharge of a patient to an 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 beneficiaries. To enforce this prohibition, the law establishes both criminal and civil penalties.

(f) 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 beneficiaries of municipal general assistance by denying them admission when the NF's Medicaid occupancy level is below the Statewide occupancy level.

(g) Provisions for reimbursement of administrative days (nursing facility level of care) shall 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.

Recodified from N.J.A.C. 10:52-1.8 and amended by R.2000 d.29, effective January 18, 2000.

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

Substituted references to beneficiaries for references to recipients throughout; in (a), rewrote 2; in (c), inserted a new second sentence, and inserted a reference to NJ KidCare—Plan A beneficiaries in the third sentence in the introductory paragraph; rewrote former (c)5 as (d); recodified former (d) through (f) as (e) through (g); and in the new (e), deleted a former third sentence. Former N.J.A.C. 10:52-1.9, Prior authorization, recodified to N.J.A.C. 10:52-1.10.

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

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

Rewrote (a); in (c), rewrote the introductory paragraph; rewrote (d).

10:52-1.10 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. 10:52-2.10(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 or NJ FamilyCare reimbursement is subject to providing these services in accordance with the policies and procedures as outlined in N.J.A.C. 10:52-2. 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 out-lined in (d) below shall be required for inpatient and outpatient hospital services provided to a beneficiary outside the State of New Jersey, except as provided in (e) below. Hospital covered services for a beneficiary with an Eligibility Identification 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 Medical Assistance Customer Center (MACC) in the area where the beneficiary resides except as listed in (d)1 below. For a listing of MACCs, see the Directory at the end of the N.J.A.C. 10:49, Administration.

1. Requests for prior authorization of out-of-State psychiatric services shall be directed to the Mental Health Unit, Office of Utilization Management, PO Box 712, Mail Code #18, Trenton, NJ 08625-0712.

2. For a beneficiary 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 beneficiary 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 beneficiary.

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 beneficiaries who have the diagnosis of Head Injury, for whom it is medically necessary to discharge the beneficiary from a hospital or special hospital to a special program in an NF, or to home care through the Traumatic Brain Injury (TBI) Waiver Program, the hospital discharge planner or social worker shall obtain prior authorization for the placement (for either in-State or out-of-State patients) from the Office of Community Choice Options for placement in the TBI nursing facility program, or from the Division of Disabilities Services for placement in the TBI Waiver Program. 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. 10:49-22.8, 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.

Recodified from N.J.A.C. 10:52-1.9 and amended by R.2000 d.29, effective January 18, 2000.

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

Substituted references to beneficiaries for references to recipients throughout; in (a) and (f), changed N.J.A.C. references; in (b), substituted a reference to Medicaid and NJ KidCare reimbursement for a reference to Medicaid payment; and in (c), substituted a reference to Eligibility Identification Numbers for a reference to HSP (Medicaid) Case Numbers. Former N.J.A.C. 10:52-1.10, Pre-Admission screening for nursing facility (NF) placement, recodified to N.J.A.C. 10:52-1.11. Amended by R.2005 d.214, effective July 5, 2005.

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

In (b), substituted "FamilyCare" for "KidCare" preceding "reimbursement" and inserted "in N.J.A.C. 10:52-2" following "procedures as outlined"; in (d), substituted references to MACCs for references to MDOs throughout the introductory paragraph and rewrote 1; rewrote (f).

10:52-1.11 Preadmission screening for nursing facility (NF) placement

(a) The Department of Health and Senior Services is the agency responsible for administering the Preadmission Screening Program. The following is provided to hospitals so that they understand the process and the rules a hospital shall follow to ensure Medicaid or NJ FamilyCare-Plan A reimbursement for the care of individuals whose discharge planning includes placement into a nursing facility.

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

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared during the Preadmission Screening (PAS) process. The HSDP reflects the individual's current or potential problems, required care needs, the need for Preadmission Screening and Resident Review (PASRR screening) and the Track of Care, and shall be forwarded to the authorized care setting.

"Level I PASRR screen" means the process of identification of an individual diagnosed with a serious mental illness (MI) or mental retardation (MR) or both and determining whether the individual also meets the NF level of care requirements.

"Level II PASRR screen" means the process of evaluating and determining whether an individual meets NF level of care, and determining whether an individual needs specialized services for MI or MR or both. An individual who requires specialized services cannot receive those services in a NF.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health and Senior Services in accordance with N.J.A.C. 8:85-1.3 for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid and NJ Family-Care fee-for-service beneficiaries (children and adults) who, due to medical disorders, developmental disabilities, or related cognitive 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.

"Preadmission screening (PAS)" means that process by which all Medicaid eligible beneficiaries 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 professional staff designated by the Department of Health and Senior Services 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.)

"Preadmission Screening and Resident Review (PASRR)" 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 in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition. PASRR includes two levels of screening, Level I Preadmission Screening and Resident Review and Level II Preadmission Screening and Resident Review, as described in this section.

"Professional staff designated by the Department of Health and Senior Services (DHSS professional staff)" means a nurse licensed or certified in accordance with N.J.A.C. 13:37 or a social worker employed by the State or a political subdivision thereof who performs health needs assessments and care management counseling in accordance with this section.

"Specialized Services for Mental Illness (MI)" means those services which are determined to be medically indicated when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based upon 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 of the individual, specific therapies and activities are prescribed, with the following objectives: to diagnose and reduce behavioral symptoms; to improve independent functioning; and 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 authorized 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 authorized to provide.

“Track of care” means designation of the setting and scope of Medicaid/NJ FamilyCare–Plan A services as determined by the PAS process conducted by the DHSS professional staff following assessment of the Medicaid or NJ FamilyCare–Plan A beneficiary or potential Medicaid or NJ FamilyCare–Plan A beneficiary, 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.

(c) Preadmission screening (PAS) authorization shall be required prior to admission to a Medicaid certified NF of a Medicaid or NJ FamilyCare–Plan A beneficiary, or an individual who may become a Medicaid or NJ FamilyCare–Plan A beneficiary within six months following placement in a Medicaid certified NF. If the NF applicant has received psychiatric inpatient care for a year or more, a PASRR shall be performed, in addition to the PAS, prior to admission. The DHSS professional staff shall assess each individual's care needs and determine the appropriate setting for the delivery of needed services. The DHSS professional staff will authorize or deny NF placement based on service requirements at N.J.A.C. 8:85-2 and the feasibility of alternative placement and will designate the track of care, in accordance with N.J.A.C. 8:85-1.8.

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

1. A Level I PASRR screen shall be required for individuals suspected of, or diagnosed as having serious MI, MR, or both or related conditions.

2. An individual is considered to have a serious mental illness (MI) if he or she has a mental illness, such as schizophrenia, mood disorder, paranoia, panic or severe anxiety disorder, or similar condition found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-II-R; 1987 edition) (available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22269-3901 and www.psych.org) which leads to a chronic disability and which meets the PASRR 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 (MR) 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 (d)3i below. An individual with a diagnosis of MR or a related condition and a diagnosis of dementia shall receive a Level II PASRR screen prior to admission to a Medicaid certified nursing facility.

- i. “Persons with related conditions” means individuals who have a severe and chronic disability that meets all of the following conditions:

- (1) The person has a diagnosis of mental retardation (MR) or other developmental disability, such as cerebral palsy, epilepsy, autism, spina bifida or other neurological impairment; and

- (2) The person has a history or past records which show that the onset of the mental retardation or related conditions occurred prior to age 22.

4. A Level II PASRR screen shall be conducted for mentally ill or mentally retarded individuals only if the DHSS professional staff assessment results in authorization of NF placement.

- i. A Level II PASRR screen for individuals with serious MI requires that a psychiatric examination be performed by a Board eligible/certified psychiatrist or APN certified in mental health to determine the need for specialized services, in accordance with (e) below. When all reasonable efforts to secure a psychiatrist fail, an M.D. or D.O. who is not a psychiatrist may perform the examination.

- ii. A Level II PASRR screen for MR individuals will be performed by the Division of Developmental Disabilities (DDD) to determine the need for specialized services, in accordance with (e) below.

5. Hospitals shall not transfer an individual with serious MI or MR to Medicaid-certified NFs until the Level II PASRR has been conducted and the hospital has received Department of Health and Senior Services Office of Community Choice Options notification that the individual does not require specialized services.

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. After an initial PASRR assessment has been completed, the individual transferred from a nursing facility to an acute care general hospital or an individual with serious MI being transferred to a psychiatric hospital for less than one year shall not require a Level I PASRR screen or a Level II PASRR screen prior to transfer back 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.

(e) The determination of the necessity for NF services shall be performed through Preadmission Screening (PAS), as mandated by N.J.S.A. 30:4D-17.10. DHSS professional staff shall determine the necessity for nursing facility services for Medicaid and NJ FamilyCare-Plan A beneficiaries, for individuals who may become Medicaid and NJ FamilyCare-Plan A beneficiaries within six months following admission to a Medicaid certified facility, and for individuals identified as meeting PASRR Level I criteria. The Office of Community Choice Options (OCCO) having jurisdiction for the area where an acute care hospital is located has the responsibility for completing the PAS assessment regardless of the beneficiary's county of residence or anticipated county of discharge. A listing of the Offices of Community Choice Options can be obtained by writing to the Director, Division of Aging and Community Choice Options, Department of Health and Senior Services, PO Box 807, Trenton, New Jersey 08625-0807, or by accessing the DHSS Division of Consumer Support website at www.state.nj.us/health/consumer/directory.htm, or by accessing the fiscal agent website at www.njmmis.com and clicking on the "Frequently Asked Questions" tab.

1. DHSS professional staff will review the medical, nursing and social information obtained at the time of assessment, as well as any other supporting data, in order to assess the individual's care needs and determine the appropriate setting for the delivery of needed services. The professional staff designated by DHSS will authorize or deny NF placement based on the service requirements of N.J.A.C. 8:85-2 and the feasibility of alternative placement. DHSS professional staff will also designate the track of care.

i. If alternative care is available, accessible and appropriate to the needs of the individual, the request for NF placement will be denied.

ii. If an appropriate alternative placement becomes available and accessible for a person already approved for NF care and awaiting placement, the authorization for NF placement will be rescinded.

iii. The DHSS professional staff will advise the hospital discharge planner or social worker of the NF level of care approval and the setting for the delivery of needed services. If the individual requires a Level II PASRR screen, a letter will be given to the individual

advising him or her that the Level II PASRR screen must be completed prior to admission to the NF.

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

3. A signed Release of Information form shall be obtained from the potentially Medicaid-eligible patient. If the patient refuses NF placement, home care services, or participation in the PAS assessment process, the DHSS professional staff will make every effort to obtain a signed participation declination statement, which will be included in the patient's OCCO case record.

4. NF placement approval: The DHSS professional staff will verbally advise the hospital discharge planner or social worker and patient or legal representative of the assessment decision.

i. For a Track I or II determination, the DHSS professional staff will leave a copy of the HSDP and signed approval letter with the discharge planner or social worker. For individuals requiring a Level II PASRR screen, the signed approval letter and HSDP shall be forwarded only after the determination has been made that no specialized services are required.

ii. For a Track III determination, the DHSS professional staff will leave a copy of the HSDP with the discharge planner or social worker to forward to the home care provider. The discharge planner or social worker shall arrange needed home health services and forward a copy of the HSDP 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 DHSS professional staff will be sent by the OCCO to the individual or his or her legal representative with copies to the county board of social services (CBOSS).

iv. A copy of the HSDP that was left with the hospital discharge planner or social worker by the DHSS professional staff will 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/Medicaid participating NF.

5. NF placement denial: The DHSS professional staff will verbally advise the hospital discharge planner or social worker and patient or the patient's legal representative of the assessment decision. The DHSS professional staff will leave a signed copy of the NF placement denial letter with the discharge planner or social worker. The

original denial letter, signed by the DHSS professional staff, will be sent to the patient or the patient's legal representative by the OCCO, with copies to the county board of social service (CBOSS).

(f) The hospital discharge planner or social work staff shall be responsible for identifying a Medicaid or NJ FamilyCare-Plan A beneficiary inpatient or a Medicaid or NJ FamilyCare-Plan A 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 or NJ FamilyCare-Plan A beneficiary within six months after NF admission as well as individuals meeting PASRR Level I criteria. (See N.J.A.C. 10:52-1.9(c).) These patients shall be referred by the hospital to the OCCO and the CBOSS on the basis of the "At Risk Criteria for Nursing Facility Placement and Referral to the OCCO for PAS Evaluation" in (g) below. Medicaid or NJ FamilyCare-Plan A beneficiaries already residing in Medicaid participating facilities who are transferred to an acute care hospital and who are transferred 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 or social worker shall:

(1) Make a telephone or FAX referral to the OCCO and the CBOSS;

(2) If not already a Medicaid or NJ FamilyCare-Plan A beneficiary, generate a Public Assistance Inquiry (PA-1C) to initiate the application process for Medicaid or NJ FamilyCare-Plan A; and

(3) Within two working days of the telephone referral to the OCCO and CBOSS, the Hospital Discharge Planning Office shall forward the completed "Hospital Preadmission Screening Referral (LTC-4)" to the OCCO, unless the LTC-4 was faxed on the day of the referral.

2. The Level II PASRR screen for MI individuals shall be completed by a Board eligible or Board certified psychiatrist or APN certified in mental health, or, when all reasonable efforts to secure a psychiatrist fail, an M.D. or D.O. who is not a psychiatrist may perform the examination as follows:

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

ii. Within 48 hours of completion of the psychiatric evaluation, the completed "Psychiatric Evaluation" form shall be faxed to (609) 777-0662 or mailed to the Division of Mental Health Services, PO Box 727, Trenton, New Jersey 08625-0727, Attention: PASRR Coordinator.

(1) A copy of the "Psychiatric Evaluation" form may be requested from the PASRR Coordinator in the Division of Mental Health Services.

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

iv. DMHS or DDD shall notify the OCCO of the determination of need for specialized services who, in turn, shall provide the hospital discharge planning unit or social services department with the approval or denial decision for placement in a Medicaid-certified NF.

(g) The following "At-Risk Criteria for Nursing Facility Placement and Referral to the OCCO 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:

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

i. Catastrophic illness requiring major changes in lifestyle or living conditions, such as multiple sclerosis, stroke, multiple trauma, AIDS, amputation, neurological disease, cancer, birth defect(s) or end stage renal disease;

ii. Debilitation or chronic illness causing progressive deterioration of self-care skills, such as severe chronic disease, spina bifida, progressive pulmonary disease or diabetes;

iii. Multiple hospital admissions within the past six months not including patients admitted directly from NFs;

iv. Previous NF admissions within the past two years; or

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

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

i. Homeless;

ii. Lives alone and/or has no immediate support system;

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

iv. Lack of adequate support systems.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rewrote the section.

10:52-1.12 Recordkeeping

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Hernia Repair (common abdominal wall type);

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

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

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

3. Laminectomy;

4. Spinal fusion;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:52-1.14 Social Necessity Days

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

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

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

3. Medicaid or NJ Family Care-Children's Program reimbursement for social necessity shall be made to hospitals paid in accordance with the DRG rate setting methodology in N.J.A.C. 10:52-5 through 7 and 9 prior to August 3, 2009 and in accordance with N.J.A.C. 10:52-14 on or after August 3, 2009.

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

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

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

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

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

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

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

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

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

Amended by R.2009 d.249, effective August 3, 2009.

See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

In (a)3, inserted "7 and" and "prior to August 3, 2009 and in accordance with N.J.A.C. 10:52-14 on or after August 3, 2009".

10:52-1.15 Utilization control (inpatient services)

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

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

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

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

reviews of inpatient hospital services shall be conducted by Quality Improvement Organizations (QIOs), which shall be reimbursed by the State once a contract has been secured to provide these services in accordance with N.J.A.C. 10:52-14.6(a)2i. Included under utilization control are: Certification and recertification of the need for inpatient care; medical, psychiatric and social evaluations; a plan of care established and periodically reviewed and evaluated by a physician; and a continuous program of utilization review under which the admission of each beneficiary is reviewed or screened. Hospital entitlement to Medicaid and NJ FamilyCare reimbursement for services rendered to a Medicaid or NJ FamilyCare fee-for-service beneficiary for each period of hospitalization shall be subject to the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Each medical evaluation shall include the following:

i. Diagnoses;

ii. Summary of present medical findings;

iii. Medical history;

iv. Mental and physical functional capacity;

v. Prognoses; and,

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

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

1. The plan of care shall include:

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

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

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

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

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

vi. Plans for discharge, as appropriate.

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

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

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

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

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

- ii. Assessing the potential resources of the beneficiary'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.

Recodified from N.J.A.C. 10:52-1.15 and amended by R.2000 d.29, effective January 18, 2000.

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

Substituted references to beneficiaries for references to recipients throughout; in (b), inserted "before the NJ KidCare beneficiaries reach age 19 and" in the introductory paragraph; and in (c)3 and (e)2, inserted references to NJ KidCare. Former N.J.A.C. 10:52-1.16, Utilization control; outpatient psychiatric services, recodified to N.J.A.C. 10:52-1.17.

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

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

Rewrote the section.

10:52-1.17 Utilization control; outpatient psychiatric services

(a) The following requirements 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 plan of care, 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. 10:52-2.10); psychological testing; and medication management.

(b) The intake evaluation shall be performed as follows:

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

- i. Evaluates the beneficiary'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 evaluation team requirements 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 plan of care requirements shall be as follows:

1. A written individualized plan of care shall be developed by the evaluation team for each patient who receives continued treatment. The plan of care 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 plan of care 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 plan of care.

(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 plan of care.

2. Clinical progress, complications and treatment which affect prognosis 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. 10:52-2.11), a departure from the plan of care 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) Periodic reviews shall be conducted as follows:

1. The evaluation team shall periodically review the patient's plan of care 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 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).

Recodified from N.J.A.C. 10:52-1.16 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a) and (e), changed N.J.A.C. references; and in (b), substituted references to beneficiaries for references to recipients throughout. Amended by R.2005 d.214, effective July 5, 2005.

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

Rewrote the section.

10:52-1.18 Advance directives

All hospitals participating in the New Jersey Medicaid/NJ FamilyCare program are subject to the provisions of State and Federal statutes regarding advance directives including, but not limited to, appropriate notification to patients of their rights, development of policies and practices and communication to, and education of, staff, community and interested parties. See N.J.A.C. 10:49-9.15, and sections 1902(a)(58), and 1902(w)(1) of the Social Security Act (42 U.S.C. §§ 1396a(a)(58) and 1396a(w)) for detailed information.

New Rule, R.2001 d.294, effective August 20, 2001.

See: 32 N.J.R. 2687(b), 33 N.J.R. 2808(a).

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

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

Substituted "FamilyCare" for "KidCare" in the first sentence and rewrote the last sentence.

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 any distinct entity that operates for the purpose of providing surgical services to patients not requiring hospitalization which has an agreement with the Centers for Medicare & Medicaid Services (CMS) to participate in the Medicare program and meets the specific conditions for coverage set forth in Federal regulations in 42 CFR Part 416.

(b) An ASC, as described in N.J.A.C. 10:66-5, 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 and administratively and shall be financially independent and distinct from other operations of the hospital.

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

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

In (b)1, changed N.J.A.C. reference in the introductory paragraph.

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

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

Rewrote the section.

10:52-2.2 Blood and blood products

(a) Reimbursement may be made for blood 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, may be reimbursed with the following limitations:

1. Efforts should be made by the family or the provider to arrange for the replacement of blood. This can be done by the contribution of a blood donor or by using a blood replacement plan in which the Medicaid or NJ FamilyCare fee-for-service eligible beneficiary is a beneficiary of the blood replacement plan (if available).

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

3. In order to obtain Medicaid/NJ FamilyCare reimbursement, the hospital shall submit a certification that a voluntary blood donation cannot be obtained.

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.

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

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

5. Nine months;
6. Twelve months;
7. Fifteen months;
8. Eighteen months;
9. Twenty-four months; and
10. Annually through 20 years of age.

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

Rewrote (a); in (b), changed N.J.A.C. reference; in (c), substituted references to beneficiaries for references to recipients throughout, and inserted a reference to NJ KidCare—Plan A fee-for-service beneficiaries and changed N.J.A.C. reference in 5i; and in (c)liv(5), substituted “ova” for “oral” preceding “and parasites”.

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

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

Rewrote the section.

10:52-2.5 Family planning services

(a) Family planning services shall include 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.

(b) The Norplant System (NPS) shall be a Medicaid and NJ FamilyCare fee-for-service covered service when provided as follows:

1. The NPS is used only in reproductive age women with established regular menstrual cycles;
2. The Food and Drug Administration (FDA) approved physician prescribing information is followed; and
3. 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.

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

(d) Only two insertions and two removals of the NPS per beneficiary shall be permitted during a five year continuous period.

(e) The hospital shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, an intrauterine device.

(f) 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 shall not be covered services, except:

1. 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 Provider Relations, PO Box 712, Mail Code #27, Trenton, New Jersey 08625-0712.

New Rule, R.2000 d.29, effective January 18, 2000.

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

Former N.J.A.C. 10:52-2.5, Home health agencies; hospital-based, recodified to N.J.A.C. 10:52-2.6.

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

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

In (b), substituted “FamilyCare” for “KidCare—Plan A, B and C” in the introductory paragraph; in (f), deleted “Medical Affairs and” preceding “Provider Relations” and substituted “27” for “14” following “Mail Code #” in 1.

10:52-2.6 Home health agencies; hospital-based

(a) A home health agency (hospital-based) shall be licensed by the New Jersey State Department of Health and Senior Services; certified as a home health agency under Title XVIII (Medicare); possess 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 pathologist, medical 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 beneficiary. Only medically necessary home health services shall be reimbursed by the Division.

(c) Division requirements for 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 Unisys Provider Enrollment, PO Box 4804, Trenton, N.J. 08650, or the website www.njmms.com and click on the Provider Enrollment Application. The application can be completed online or downloaded and mailed or faxed to Unisys at (609) 584-1192.

Recodified from 10:52-2.5 and amended by R.2000 d.29, effective January 18, 2000.

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

In (b), substituted a reference to speech pathologists for a reference to speech-language pathologists, and substituted a reference to beneficiaries for a reference to recipients. Former N.J.A.C. 10:52-2.6, Medical day care centers; hospital affiliated, recodified to N.J.A.C. 10:52-2.7.

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

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

In (b), inserted “medical” preceding “social worker” in the first sentence, substituted “beneficiary” for “beneficiaries” following “each” in the second sentence and substituted “shall be” for “are” preceding “reimbursed” in the last sentence; rewrote (c).

10:52-2.7 Medical day care centers; hospital affiliated

(a) An adult or pediatric day health services facility shall be affiliated and identified as part of a hospital which is licensed by the New Jersey State Department of Health and Senior Services, in accordance with its Manual of Standards for Licensure of Adult and Pediatric Day Health Services and shall possess a valid and current provider agreement from the Division.

(b) Adult Day Health Services 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 but, due to their physical or mental impairment, need health maintenance and restorative services to live in the community. Pediatric Day Health Services is a program which provides additional health-related services in order to provide for the needs of technology-dependent or medically unstable children.

(c) The Department of Health and Senior Services administers the Medicaid and NJ FamilyCare fee-for-service Adult Day Health Services and Pediatric Day Health Services programs. For program requirements, see N.J.A.C. 8:86.

1. Medical day care transportation services shall not be reimbursed by the fiscal agent as a separate service.

2. All direct and indirect costs associated with hospital-affiliated medical day care centers shall be reported separately on New Jersey State Department of Health and Senior Services 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 beneficiary on the same day.

Recodified from 10:52-2.6 and amended by R.2000 d.29, effective January 18, 2000.

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

Rewrote (c); in (d), substituted a reference to beneficiaries for a reference to recipients; and deleted a former (e). Former N.J.A.C. 10:52-2.7, Narcotic and drug abuse treatment centers; fee-standing, recodified to N.J.A.C. 10:52-2.8.

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

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

Rewrote (a), (b), and the introductory paragraph of (c).

10:52-2.8 Substance abuse treatment centers; free-standing

(a) Division requirements for substance abuse treatment centers are located in N.J.A.C. 10:66, Independent Clinic Services. Services provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by a free standing hospital-affiliated substance 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 and Senior Services 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 substance 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 for Medicaid and NJ FamilyCare-Plans A and B. For NJ FamilyCare-Plan C, the Division's payment shall be considered as payment in full except for the Division's requirements regarding the personal contribution to care responsibilities of the NJ FamilyCare-Plan C beneficiaries which are codified at N.J.A.C. 10:49-9 and 10:52-4.7. Mental health and substance abuse services for beneficiaries of NJ FamilyCare-Plans A, B and C who are also clients of the Division of Developmental Disabilities are provided by their HMO.

(c) Substance abuse rehabilitative services provided to NJ FamilyCare-Plan D beneficiaries either by the HMO or the Department of Human Services shall not be reimbursed. Inpatient and outpatient substance abuse services for Plan D beneficiaries shall be limited to detoxification. Inpatient and outpatient substance abuse rehabilitative services provided to Plan H beneficiaries shall not be reimbursed.

(d) 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 (CMS 1500 Health Insurance Claim Form).

Recodified from 10:52-2.7 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), inserted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries in the introductory paragraph; and rewrote (b). Former N.J.A.C. 10:52-2.8, Organ procurement and transplantation services, recodified to N.J.A.C. 10:52-2.9.

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

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

In (a), rewrote the introductory paragraph; rewrote (b); added a new (c); recodified former (c) as (d) and substituted "CMS 1500" for "1500 N.J." in the last sentence.

10:52-2.9 Organ procurement and transplantation services

(a) The Division shall reimburse for medically necessary transplantation services, including organ procurement, except those transplants categorized as experimental. (See (d) below for further information on organ procurement and transplantation.)

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

(b) 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 (42 U.S.C. § 1320).

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 Senior Services and Human Services as the OPO for that geographical area in which the hospital is located.

(c) 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.

(d) The candidate for transplantation shall have been accepted for the procedure by the transplant center. All out-of-State hospitalizations for transplantations shall require prior authorization from the Medical Assistance Customer Center (MACC) serving the beneficiary's county of residence.

(e) 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)).

(f) For organ transplants for Medicaid or NJ FamilyCare beneficiaries enrolled with a managed care organization, the managed care organization shall be responsible for all costs, except for the costs of the hospital, for an individual placed on a transplant list while in the Medicaid fee-for-service program prior to enrollment in a managed care organization under contract with the Department of Human Services. Included in the hospital costs are the costs of procuring the organ.

Recodified from 10:52-2.8 and amended by R.2000 d.29, effective January 18, 2000.

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

In (b)1 and (e), substituted references to beneficiaries for references to recipients throughout; in (e), substituted a reference to the Office of Health Service Administration for a reference to the Office of Medical Affairs and Provider Relations; and added (h). Former N.J.A.C. 10:52-2.9, Psychiatric services; partial hospitalization, recodified to N.J.A.C. 10:52-2.10.

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

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

Rewrote the section.

10:52-2.10 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 or NJ FamilyCare fee-for-service beneficiary. 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 require prior authorization from the Division after the first 30 calendar days from the first date of treatment. Prior authorization from the Division shall not be required for the first 30 calendar days beginning 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.

(d) Prior authorization for PH from the Division shall be required after the first 30 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 plan of care 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 "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD-07)" and the "Request for Prior Authorization: Supplemental Information (FD-07A)" forms to the Medical Assistance Customer Center that serves the county in which the services are rendered.

3. The notification of the disposition (approved, modified, denied, or suspended) of the prior authorization request will be made by the Division's 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/NJ FamilyCare.

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

5. 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 beneficiary on the same day.

6. The smallest unit of partial hospitalization that may be prior authorized by NJ Medicaid/FamilyCare is one hour, with a minimum of two hours per day and a maximum of five hours per day. For example, prior authorization for a full day of partial hospitalization (five hours) shall be reflected as five units, four hours shall be reflected as four units, a half day (three hours) shall be reflected as three units, and two hours shall be reflected as two units.

(e) Mental health services provided by or through the partial hospitalization program shall not include:

1. Student education, including preparation of school-assigned classwork or homework; or

2. Incentive programs, including, but not limited to, non-therapeutic token economies and subcontract work responsibilities.

Recodified from 10:52-2.9 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients in the introductory paragraph; and in (d), substituted a reference to the Division's fiscal agent for a reference to the Medicaid fiscal agent and added a reference to NJ KidCare in 4, and substituted references to beneficiaries for references to recipients in 5 and 6. Former N.J.A.C. 10:52-2.10, Rehabilitative services; hospital outpatient department, recodified to N.J.A.C. 10:52-2.11.

Special amendment, R.2002 d.82, effective February 15, 2002 (to expire December 21, 2004).

See: 34 N.J.R. 1279(a).

Rewrote (c)1i; in (d), inserted ", except as provided in (e) below"; added (e).

Special amendment, R.2002 d.191, effective May 24, 2002 (to expire December 21, 2004).

See: 34 N.J.R. 2149(a).

In (c), rewrote 1i; in (d), substituted "30" for "90" and deleted ", except as provided in (e) below"; deleted (e).

Amended by R.2003 d.182, effective May 5, 2003.

See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).

Rewrote (d)2.

Amended by R.2004 d.75, effective February 17, 2004.

See: 35 N.J.R. 2154(a), 36 N.J.R. 952(b).

In (d), inserted a new 7; added (e).

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

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

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service" in the introductory paragraph; in (d), deleted former 3, recodified former 4 as 3 and substituted "FamilyCare" for "KidCare", and recodified former 5 through 7 as 4 through 6.

10:52-2.10A Psychiatric services; partial hospitalization prevocational programs

(a) The provisions of this section shall apply when prevocational services are provided within a partial hospitalization program, in accordance with N.J.A.C. 10:52-2.10(a)8.

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

"Mental health services worker" means an individual who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

"Prevocational services" means interventions, strategies and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as: responding to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and adherence to prescribed medication directions/schedules. Examples of interventions not considered prevocational or covered by Medicaid and NJ FamilyCare include: technical occupational skills training, college preparation, student education, including preparation of school assigned classwork or homework and individualized job development.

“Special minimum wage certificate” means a certificate issued by the U.S. Department of Labor pursuant to 29 C.F.R. § 525, which permits a worker with a disability to be paid at a rate below the rate which would otherwise be required by statute.

“Therapeutic subcontract work activity” means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program by the U.S. Department of Labor.

“Vocational services” means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(c) The Division will reimburse a provider for prevocational services provided within the context of a partial hospitalization program, in accordance with this section.

(d) Prevocational services shall be those interventions, strategies and activities within the context of a partial hospitalization program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as responding appropriately to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and medication adherence. Services or interventions which are not considered prevocational will not be reimbursed by the Medicaid/NJ FamilyCare programs. Examples of services or interventions not considered to be prevocational include:

1. Technical or occupational skills training;
2. College preparation;
3. Student education, including preparation of school-assigned classwork or homework; and
4. Individualized job development.

(e) The Division will not reimburse any provider for vocational services provided within the context of a partial hospitalization program.

1. Vocational services means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(f) When, in the judgment of the treatment team, an individual is appropriate for discharge or referral to another

employment-related service provider or situation, and, has demonstrated mastery of individualized goals and objectives, such as: an ability to respond appropriately to criticism, make decisions, negotiate for needs, deal with interpersonal issues, manage psychiatric symptoms and adhere to medication prescriptions, the service provider shall:

1. Update the individual treatment goal;
2. Revise the discharge plan; and
3. Refer the individual to a community work setting, if such referral is appropriate for the individual.

(g) The Division will reimburse prevocational services provided to eligible beneficiaries within the context of a partial hospitalization program when the services consist of therapeutic subcontract work activity, and when all of the following requirements are met:

1. The therapeutic subcontract work activity shall consist of production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage, and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program, by the U.S. Department of Labor;
2. The individuals plan of care shall contain a stipulation that the therapeutic subcontract work activity is a form of intervention intended to address the individual deficits of the patient as identified in the clients assessment;
3. The therapeutic subcontract work activity shall be facilitated by a qualified mental health services worker;
4. The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health services worker; and
5. The staff to client ratio shall not exceed a ratio of 1:10 qualified mental health services worker to client.

New Rule, R.2004 d.75, effective February 17, 2004.
See: 35 N.J.R. 2154(a), 36 N.J.R. 952(b).

10:52-2.11 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 pathology and audiology services, and the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services and other restorative services shall be provided for the purpose of attaining maximum reduction in disability and restoration of a Medicaid beneficiary to his or her highest possible functional level. Rehabilitative services shall be made available to Medicaid/NJ Family-

Care beneficiaries as an integral part of a comprehensive medical program.

2. "Occupational therapy" means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist. These services include necessary supplies and equipment.

3. "Qualified 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 Committee on Allied Health Education and Accreditation 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 or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified physical therapist. These services include necessary supplies and equipment.

5. "Qualified physical therapist" means an individual who is:

i. Licensed by the State of New Jersey as a physical therapist in accordance with N.J.A.C. 13:39A;

ii. A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and

iii. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

6. "Speech-language pathology" and "audiology services" mean 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 is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with N.J.A.C. 13:44C, and who meets all applicable Federal requirements including:

i. A certificate of clinical competence in Speech-Language Pathology (CCC-SLP) or Audiology (CCC-A) from the American Speech-Language-Hearing Association (American Speech-Language-Hearing Association, 10801 Rockville Pike, Rockville, MD 20852, or <http://www.asha.org>); or completion of the equivalent educational requirements and work experience necessary for the certificate; or completion of the academic program and is in the process of acquiring supervised work experience in order to qualify for the certificate; and

ii. If treatment or services are provided in a state other than New Jersey, the speech-language pathologist or audiologist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements;

iii. If the attending physician orders an evaluation for speech-language therapy, the speech-language pathologist may make an initial visit for a screening examination. If, as a result of the screening examination, a comprehensive evaluation is necessary, the comprehensive evaluation shall be completed at the same time as the screening examination, or at the earliest mutual convenience of the patient and the provider;

iv. An initial comprehensive speech-language pathology evaluation should last approximately three hours, and shall include, as an integral part of the evaluation, a written report, as well as discussion and consultation with the patient or family, or both, regarding the findings;

v. The Division shall reimburse for either a screening examination or a comprehensive speech-language evaluation rendered to a beneficiary, but not both. If the documentation reveals that the screening examination did not support the need for a comprehensive evaluation, the request for reimbursement will be downgraded to Speech-Language Therapy—Initial Visit Screening Examination, and reimbursed accordingly.

(b) All treatment services shall be prescribed by a physician and provided by or under the direction or personal supervision of the appropriate qualified practitioner of the healing arts.

(c) A plan of treatment shall be completed during the beneficiary's initial evaluation visit for rehabilitative service(s) and shall be retained on file.

1. The plan of treatment shall be definitive as to the modality, amount of time per treatment, frequency and duration of the rehabilitative services to be furnished. The beneficiary's diagnosis and the anticipated goal(s) of the treatment shall be included in the treatment plan.

(d) A re-evaluation shall be performed at the end of a course of treatment to determine the need to continue with or change the treatment modality.

Recodified from 10:52-2.10 and amended by R.2000 d.29, effective January 18, 2000.

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

Rewrote the section. Former N.J.A.C. 10:52-2.11, Renal dialysis services for end-stage renal disease (ESRD), recodified to N.J.A.C. 10:52-2.12.

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

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

Rewrote the section.

10:52-2.12 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 and Senior Services 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 or NJ FamilyCare fee-for-service beneficiary 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 or NJ FamilyCare fee-for-service only when the individual is a Medicaid or NJ FamilyCare fee-for-service beneficiary and not a Medicare beneficiary, or during the time frame when ESRD services 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 or NJ FamilyCare fee-for-service beneficiary 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.

Recodified from 10:52-2.11 and amended by R.2000 d.29, effective January 18, 2000.

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

In (b), substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients/patients; and in (c), substituted references to beneficiaries for references to recipients and inserted references to NJ KidCare fee-for-service

throughout. Former N.J.A.C. 10:52-2.12, Sterilization, recodified to N.J.A.C. 10:52-2.13.

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

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

In (c), substituted "services" for "benefits" preceding "are not Medicare reimbursable" in the introductory paragraph; substituted "Family-Care" for "KidCare" preceding "fee-for-service" throughout.

10:52-2.13 Sterilization

(a) The Division covers sterilization procedures performed on Medicaid or NJ FamilyCare fee-for-service beneficiaries based on 42 CFR 441.250 through 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 medical 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.

5. If a hospital is not satisfied with the Division's determination, the hospital may request an administrative hearing pursuant to N.J.A.C. 10:49-10. If the 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, adopting, modifying or rejecting the Administrative Law Judge's initial decision. Thereafter, review may be sought in the Appellate Division.

(c) Prior authorization shall be required for patients with prognoses that necessitate lengths of stay in excess of 30 days. Reimbursable patient days shall be subject to utilization review requirements as specified in N.J.A.C. 10:52-1.15.

(d) The Medicaid and NJ FamilyCare program will reimburse special hospitals (Classification C) according to the rules and reimbursement methodology of N.J.A.C. 8:85, Long Term Care Services.

(e) 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 for inpatient services in acute care general hospitals.

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

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

In (b), substituted a reference to the Medicaid and NJ KidCare program for a reference to the Division; and in (c), deleted N.J.A.C. reference.

Amended by R.2002 d.376, effective November 18, 2002.
See: 34 N.J.R. 2247(a), 34 N.J.R. 2549(b), 34 N.J.R. 3980(b).

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

In (a), substituted "2001" for "2002" preceding "; c.393"; in (d), substituted "FamilyCare" for "KidCare" preceding "program" and amended the N.J.A.C. reference.

10:52-4.3 Basis of payment: all general and special (Classification A), rehabilitation (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care hospitals—outpatient services

(a) The Division shall reimburse general hospitals, special hospitals (Classification A), rehabilitation hospitals (Classification B), private and governmental psychiatric hospitals, and distinct units of acute care 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. 10:52-1.3(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 413.1; 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 413.1. 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.

i. Hospitals shall notify the Division of any changes made to the hospital's charge structure or cost-to-charge ratios. Notice shall be given 30 days prior to implementation of the change, in writing, addressed to:

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

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) private and governmental psychiatric hospitals, and distinct units of acute care 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 including the fiscal year ending June 30, 2001, 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 (CMS-2552). This reduction shall be calculated when the Medicare Cost Report (CMS-2552) is finalized and if the report is amended. Effective for fiscal years ending on or after July 1, 2001, the Division shall reduce hospital outpatient capital cost by 10 percent and the reasonable cost of hospital outpatient services (net of the outpatient capital cost) by 5.8 percent. The 5.8 percent reduction will be calculated during the interim and final settlement process of the Medicare cost report (CMS-2552) and if the report is amended. The 10 percent outpatient capital cost reduction will be calculated at final settlement and if the cost report is amended. The reduction shall apply to general, special (Classification A), rehabilitation (Classification B) and private and governmental psychiatric hospitals, and distinct units of acute care hospitals.

(b) Certain outpatient services, that is, most laboratory services, all renal dialysis services, all dental services, some HealthStart services, Medicare deductible and coinsurance amounts and all outpatient psychiatric services 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 schedule using the Healthcare Common Procedure Coding System (HCPCS) procedure codes and the fee schedule contained in the N.J.A.C. 10:52-10. 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) shall be 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 GO001 and 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 NJ KidCare 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 NJ FamilyCare fee-for-service 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. 10:52-10.1;

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) shall be reimbursed at 100 percent of the composite rate and shall include 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 pediatric continuity of care services shall be reimbursed on a fee-for-service basis in the hospital outpatient department. All other HealthStart maternity and pediatric care services shall be reimbursed based on the cost-to-charge ratio. See N.J.A.C. 10:52-3.16.

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 or NJ FamilyCare fee-for-service 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 shall not be subject to the cost-to-charge ratio and are reimbursed at 100 percent of the amounts.

8. All outpatient psychiatric services provided to individuals 21 years of age and over shall be paid at the lower of charges or prospective unit rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rewrote (a).

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

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

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

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

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

Rewrote the section.

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

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

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

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

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

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

10:52-4.4 Basis of payment; hospital capital project adjustment

(a) Any qualifying hospital that has completed a capital facilities construction project with an approved certificate of need from the New Jersey Department of Health and Senior Services, which meet both conditions in (a)1 below will be eligible for increased payments for capital project funding related to its Medicaid and NJ FamilyCare-Plan A managed care utilization.

1. The conditions required in (a) above are:

i. The approval 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 as of September 15, 1997; and

ii. 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. Payments to eligible hospitals shall begin upon project completion and facility operation.

3. 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 FamilyCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

New Rule, R.2009 d.249, effective August 3, 2009.

See: 41 N.J.R. 1351(a), 41 N.J.R. 2895(a).

Former N.J.A.C. 10:52-4.4, Basis of payment and appeal procedure; out-of-State hospital services, recodified to N.J.A.C. 10:52-4.5.

10:52-4.5 Basis of payment and appeal procedure; out-of-State hospital services

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

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

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

2. An out-of-State hospital should provide official documentation of the Medicaid rate that has been established by the State Medicaid agency in the state in which the hospital is located.

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

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

1. 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).
Recodified from N.J.A.C. 10:52-5.12 and amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

10:52-5.9 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/NJ FamilyCare fee-for-service inpatients;
2. Current physician patient service costs, as modified for physician compensation arrangements pursuant to N.J.A.C. 10:52-5.8;
3. Indirect cost pursuant to N.J.A.C. 10:52-5.7 and 5.12;
4. Less a reduction for income not related to patient care, from those sources specified in N.J.A.C. 10:52-6.25 through 6.31 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. 10:52-5.13.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).
Recodified from N.J.A.C. 10:52-5.13 and amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

In (a), inserted a reference to NJ KidCare fee-for-service inpatients in 1, and changed N.J.A.C. references in 2 through 4. Former N.J.A.C. 10:52-5.9, Current Cost Base, recodified to N.J.A.C. 10:52-5.5. Amended by R.2005 d.214, effective July 5, 2005.
See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

In (a), substituted "FamilyCare" for "KidCare" preceding "fee-for-service inpatients" in 1; in (b), amended the N.J.A.C. reference.

10:52-5.10 Standard costs per case

(a) The standard to be used in the calculation of the proposed rates 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 data base, and adjusted for labor market differentials and amount and type of Graduate Medical Education (GME). 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/NJ Family-Care fee-for-service case in all hospitals whose costs are included in the data base, 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 Senior Services; 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, |

- | | |
|---|---|
| vi. Jersey City | Counties or Municipalities |
| vii. New Brunswick—Perth Amboy | Belleville, East Orange, Irvington and Newark |
| viii. Long Branch—Toms River | Hudson |
| ix. Atlantic City—Cape May | Middlesex |
| x. Vineland—Millville | Monmouth, Ocean |
| Camden—Salem | Atlantic, Cape May |
| xi. Newark, Central City (not included in v. above) | Burlington, Gloucester |
| | Cumberland |
| | 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 hospital's 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/NJ FamilyCare fee-for-service 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/NJ FamilyCare fee-for-service hospital inpatient rates. GME is removed by removing cost centers that contain adjusted GME costs before the direct patient care (DPC) rate is set. IME is removed from the DPC rate by multiplying by one minus the Indirect Medical Education (IME) factor based on the Medicare cost report and the fiscal agent's settlement data. GME and IME shall be reimbursed in accordance with N.J.A.C. 10:52-8.

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.

Recodified from N.J.A.C. 10:52-5.14 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a)2, inserted a reference to NJ KidCare fee-for-service cases; and in (f), substituted references to Medicaid/NJ KidCare fee-for-service for references to Medicaid throughout, and changed N.J.A.C. reference. Former N.J.A.C. 10:52-5.10, Financial elements reporting/auditing adjustments, recodified to N.J.A.C. 10:52-5.6.

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

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

In (a), substituted "data base" for "date base" preceding ", and adjusted for labor market differentials" and inserted "(GME)" following "Graduate Medical education" in 1, and substituted "FamilyCare" for "KidCare" preceding "fee-for-service case" in 2; in (b), substituted "must submit a letter" for "must a submit letter" in 3ii; rewrote (f).

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.

10:52-5.11 Reasonable direct cost per case

(a) Inpatient direct cost per case shall be determined as follows:

1. The reasonable direct cost per Medicaid/NJ FamilyCare fee-for-service 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:

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

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

In (a), substituted a reference to Medicaid/NJ KidCare fee-for-service rates for a reference to Medicaid rates.

Repealed and New Rule, R.2005 d.214, effective July 5, 2005.

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

Section was "Reporting period".

10:52-6.2 (Reserved)

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

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

Section was "Objective evidence".

10:52-6.3 (Reserved)

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

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

Section was "Consistency".

10:52-6.4 (Reserved)

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

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

Section was "Full disclosure".

10:52-6.5 (Reserved)

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

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

Section was "Materiality".

10:52-6.6 (Reserved)

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

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

Section was "Basis of valuation".

10:52-6.7 (Reserved)

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

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

Section was "Accrual accounting".

10:52-6.8 (Reserved)

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

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

In (a), inserted ", but is not limited to," following "includes", and substituted "and buckets" for ", buckets, etc." following "mops" in the introductory paragraph.

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

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

Section was "Accounting for minor moveable equipment".

10:52-6.9 (Reserved)

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

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

In (b), inserted ", but are not limited to," following "include", and substituted "and walls" for ", walls, etc." following "fences"; and in (g)6i, changed N.J.A.C. reference.

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

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

Section was "Accounting for capital facilities costs".

10:52-6.10 (Reserved)

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

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

Section was "Timing differences".

10:52-6.11 (Reserved)

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

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

Section was "Self-insurance".

10:52-6.12 (Reserved)

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

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

Section was "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; and preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements. All non-direct costs must be allocated based upon the proportion of Medicaid/NJ FamilyCare fee-for-service beneficiaries 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).

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

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

Substituted a reference to Medicaid/NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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

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

Substituted "State; and preservation" for "State; preservation" preceding ", replacement and improvement", deleted "; reasonable working capital; and where applicable and appropriate, reasonable return on investment" following "planning requirements", and substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiaries".

10:52-6.14 Services related to Medicaid/NJ FamilyCare fee-for-service patient care

(a) Services related to 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 6.17.

(b) Services Related to Patient Care include Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services. Costs Related to 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. 10:52-6.20 through 6.24.

(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.

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

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

In (a) and (b), deleted "Medicaid" preceding "Patient", and changed N.J.A.C. references.

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

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

10:52-6.15 Direct patient care

Direct patient care is the provision by a hospital of medically necessary and appropriate health care services to a Medicaid/NJ FamilyCare fee-for-service beneficiary.

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

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

Deleted "Medicaid" at the beginning, and substituted a reference to MEDicaid/NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

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

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

Substituted "FamilyCare" for "KidCare" preceding "fee-for-service beneficiary".

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 programs

(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 Commissioner of the Department of Health and Senior Services. 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 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.

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

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

In (b), substituted a reference to the Commissioner of the Department of Health and Senior Services for a reference to the Commission.

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).

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

10:52-6.20 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. Medicare manuals are available via the Internet from www.cms.gov. To obtain paper copies of the Medicare HIM-15 document or other Medicare manuals write to:

Department of Health and Human Services
Centers for Medicare & Medicaid Services
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 Income 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	
Life Insurance	Salaries
Employee Education and Training	Salaries or 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. 10:52-6.16; and insurance, other than employee fringe benefit insurance programs.

Recodified from N.J.A.C. 10:52-6.22 and amended by R.2000 d.29, effective January 18, 2000.
 See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
 In (e), changed N.J.A.C. reference.
 Amended by R.2005 d.214, effective July 5, 2005.
 See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

In (b), inserted the sentence containing the Internet site, inserted "paper copies" preceding "of the Medicare HIM-15 document" and substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration" in 1; in (d), substituted "Income" for "Insurance" following "Employee Retirement" in 2.

10:52-6.21 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.

Recodified from N.J.A.C. 10:52-6.23 by R.2000 d.29, effective January 18, 2000.
 See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

10:52-6.22 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.

Recodified from N.J.A.C. 10:52-6.24 by R.2000 d.29, effective January 18, 2000.
 See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
 Former N.J.A.C. 10:52-6.22, Natural classifications of expense, recodified to N.J.A. 10:52-6.20.

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.

Recodified from N.J.A.C. 10:52-6.70 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted "included in the Social Services (SOC) cost center" for "of the Social Services (SOC)" in the introductory paragraph. Former N.J.A.C. 10:52-6.68, Medical Records (MRD), recodified to N.J.A.C. 10:52-6.66.

10:52-6.69 Research (RSH)

(a) The functions included in the Research (RSH) cost center 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 Commissioner of the Department of Health and Senior Services in approved research. Approved research shall be reported pursuant to N.J.A.C. 10:52-6.25 through 6.27. 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.

Recodified from N.J.A.C. 10:52-6.71 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted "included in the Research (RSH) cost center" for "of the Research (RSH)" in the introductory paragraph, and substituted a reference to the Commissioner of the Department of Health and Senior Services for a reference to the Commission and changed N.J.A.C. reference in 1. Former N.J.A.C. 10:52-6.69, Pharmacy (PHM), recodified to N.J.A.C. 10:52-6.67.

10:52-6.70 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.

Recodified from N.J.A.C. 10:52-6.72 by R.2000 d.29, effective January 18, 2000.

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

Former N.J.A.C. 10:52-6.70, Social Services (SOC), recodified to N.J.A.C. 10:52-6.68.

10:52-6.71 Graduate Medical Education (GME)

(a) The functions included in the Graduate Medical Education (GME) cost center 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.

Recodified from N.J.A.C. 10:52-6.73 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted "included in the Graduate Medical Education (GME) cost center" for "of the Graduate Medical Education (GME)" in the introductory paragraph. Former N.J.A.C. 10:52-6.71, Research (RSH), recodified to N.J.A.C. 10:52-6.69.

10:52-6.72 General Administrative Services (GAM)

(a) The functions included in the General Administrative Services (GAM) cost center 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;
- 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.

Recodified from N.J.A.C. 10:52-6.74 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted "included in the General Administrative Services (GAM) cost center" for "of the General Administrative Services (GAM)" in the introductory paragraph, and substituted a reference to the Office of Hospital Administrator for a reference to the Office of Hospital Administrator Medical Administration in 2ii. Former N.J.A.C. 10:52-6.72, Nursing and Allied Health Education (EDU), recodified to N.J.A.C. 10:52-6.70.

10:52-6.73 Inpatient Administrative Services (IAM)

(a) The functions included in the Inpatient Administrative Services (IAM) cost center 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.

Recodified from N.J.A.C. 10:52-6.75 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted "included in the Inpatient Administrative Services (IAM) cost center" for "of the Inpatient Administrative Services (IAM)" in the introductory paragraph. Former N.J.A.C. 10:52-6.73, Graduate Medical Education (GME), recodified to N.J.A.C. 10:52-6.71.

10:52-6.74 Malpractice Insurance (MAL)

(a) The functions included in the Malpractice Insurance (MAL) cost center 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.

Recodified from N.J.A.C. 10:52-6.76 and amended by R.2000 d.29, effective January 18, 2000.

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

In (a), substituted "included in the Malpractice Insurance (MAL) cost center" for "of the Malpractice Insurance (MAL)" in the introductory paragraph. Former N.J.A.C. 10:52-6.74, General Administrative Services (GAM), recodified to N.J.A.C. 10:52-6.72.

10:52-6.75 Employee Health Insurance (EHI)

(a) The functions included in the Employee Health Insurance (EHI) cost center 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.

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.

1. W AGE 70 CC: Patients who are over age 70 and have a substantial complication or co-morbidity.
2. WO AGE 70 CC: Patients who are over age 70 and have no substantial complication or co-morbidity.
3. W CC: Patients with a substantial complication or co-morbidity.
4. WO CC: Patients without a substantial complication or co-morbidity.
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.

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

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

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

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

In (b), deleted "/or" preceding "have a substantial complication" in 1 and substituted "who are over age 70" for "who are age 0-70" preceding "and have no substantial complication" in 2.

SUBCHAPTER 8. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

10:52-8.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed

(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 FamilyCare-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 has been 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 FamilyCare-Plan A fee-for-service inpatient DRG payments (net of GME and IME) to arrive at the Medicaid and NJ FamilyCare-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 has been 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.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

10:52-8.2 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. 10:52-8.1, 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 FamilyCare-Plan A fee-for-service days divided by the total Medicaid and NJ FamilyCare-Plan A fee-for-services days for all teaching hospitals. The source for the GME FTEs and the Medicaid and NJ FamilyCare-Plan A fee-for-service days is the Medicare audited cost report including subsequent amendments for the year in which payment has been 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.

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

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

Changed N.J.A.C. reference.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

10:52-8.3 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 the Division's settlement agent. The settlement agent 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 FamilyCare-Plan A fee-for-service GME and IME payment based on the major teaching hospitals' submitted data and their Medicaid and NJ FamilyCare-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. 10:52-8.2 utilizing the submitted FTE count and the Medicaid and NJ FamilyCare-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. 10:52-8.4.

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.

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

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

Substituted references to the Division's settlement agent for references to Blue Cross and Blue Shield of New Jersey and changed N.J.A.C. references throughout.

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

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

Substituted "FamilyCare" for "KidCare" throughout.

10:52-8.4 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 FamilyCare-Plan A fee-for-service GME and IME final payment shall be calculated in accordance with N.J.A.C. 10:52-8.1 and distributed to all teaching hospitals in accordance with N.J.A.C. 10:52-8.2. 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.

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

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

Changed N.J.A.C. references throughout.

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

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

Substituted "FamilyCare" for "KidCare".

10:52-8.5 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 FamilyCare-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 FamilyCare-Plan A fee-for-service days shall come from the 24-month data fee-for-service Medicaid and NJ FamilyCare-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 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).

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

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

In (c), deleted "of Medical Assistance and Health Services" following "Division"; substituted "FamilyCare" for "KidCare" throughout.

10:52-8.6 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 FamilyCare-Plan A fee-for-service utilization at or above the median of all New Jersey acute care hospitals. The Medicaid and NJ FamilyCare-Plan A fee-for-service utilization is calculated using the hospital-specific Medicaid and NJ FamilyCare-Plan A fee-for-service days divided by the hospital-specific total days.

**SUBCHAPTER 10. HCFA COMMON PROCEDURE
CODING SYSTEM (HCPCS) FOR HOSPITAL
OUTPATIENT LABORATORY SERVICES****10:52-10.1 Introduction**

(a) The New Jersey Medicaid/FamilyCare fee-for-service program utilizes the Healthcare Common Procedure Coding

System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology architecture, employing a five position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the CMS assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three level coding system.

1. LEVEL I CODES (Narratives found in CPT)

These codes are adapted from CPT for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse Midwives, Certified Nurse Practitioners, Independent Clinics and Independent Laboratories. CPT 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 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT, 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 CMS for physicians and non-physician services which are not in CPT.

3. LEVEL III CODES (Narratives found at N.J.A.C. 10:52-10.3)

These codes are assigned by the Division to be used for those services not identified by CPT codes or CMS 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 the 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:

<u>Column Title</u>	<u>Description</u>
IND	<p>(Indicator Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid and NJ FamilyCare fee-for-service program's qualifications and requirements when a procedure or service code is used.</p> <p>Explanation of indicators and qualifiers used in this column are identified below:</p> <p>"A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.</p> <p>"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</p>

<u>Column Title</u>	<u>Description</u>
HCPCS CODE	<p>Jersey Medicaid or NJ FamilyCare program.</p> <p>"L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:52-10.3.</p> <p>"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.</p>
MOD	<p>Lists the HCPCS procedure code numbers.</p>
DESCRIPTION	<p>Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance has been 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.</p>
MAXIMUM FEE ALLOWANCE	<p>Lists the code narrative. (Narratives for Level I codes are found in CPT. Narratives for Level II and Level III codes are found at N.J.A.C. 10:52-10.3.)</p> <p>Lists the New Jersey Medicaid and NJ FamilyCare fee-for-service 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.</p>

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.

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

Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT-4 throughout; in (a), inserted a reference to Certified Nurse Practitioners in 1, and changed N.J.A.C. reference in 3; and in (c), inserted a reference to NJ KidCare. Amended by R.2005 d.214, effective July 5, 2005.

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

In (a), substituted "Healthcare" for "Health Care Financing Administration's (HCFA)" following "program utilizes the" in the introductory paragraph and substituted "CMS" for "HCFA" throughout; substituted references to FamilyCare for references to KidCare throughout.

10:52-10.2 HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory

<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>
	0023T		\$80.00	
N	36415		\$1.80	
	36416		\$1.80	
	36430		\$13.00	
	36440		\$30.00	
	36450		\$137.00	
	36455		\$126.00	
	36460		\$151.00	
	36516		\$49.00	
N	80048		\$9.30	
N	80050		\$36.00	
N	80051		\$5.90	
N	80053		\$10.50	
N	80055		\$15.00	
N	80061		\$15.00	
N	80069		\$9.60	
N	80074		\$30.00	
N	80076		\$7.00	
	80100		\$5.20	
	80101		\$5.20	
	80102		\$15.00	
	80150		\$15.00	
	80152		\$15.00	
	80154		\$21.50	
	80156		\$20.00	
	80157		\$10.00	
	80158		\$20.00	
	80160		\$15.00	
	80162		\$15.00	
	80164		\$10.00	
	80166		\$15.00	
	80168		\$18.00	
	80170		\$12.60	
	80172		\$1.80	
	80173		\$16.10	
	80174		\$15.00	
	80176		\$18.00	
	80178		\$9.00	

<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>
	80182		\$12.00	
	80184		\$12.80	
	80185		\$14.65	
	80186		\$19.00	
	80188		\$20.00	
	80190		\$15.00	
	80192		\$15.00	
	80194		\$15.00	
	80196		\$7.00	
	80197		\$15.00	
	80198		\$15.00	
	80200		\$12.60	
	80201		\$12.00	
	80202		\$12.00	
	80299		\$10.80	
	80400		\$34.00	
	80402		\$96.00	
	80406		\$98.00	
	80408		\$130.00	
	80410		\$102.00	
	80412		S.C.C.	
	80414		\$61.00	
	80415		\$50.00	
	80416		\$150.00	
	80417		\$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		\$74.27	
	80440		\$60.00	
	80500		S.C.C	
	80502		S.C.C	
	81000		\$1.20	
	81001		\$1.20	
	81002		\$1.00	
	81003		\$1.50	
	81005		\$1.00	
	81007		\$2.84	
	81015		\$0.40	
	81020		\$4.30	
	81025		\$3.00	
	81050		\$3.40	
	81099		S.C.C	
	82000		\$15.00	
	82003		\$26.00	
	82009		\$5.00	
	82010		\$9.90	
	82013		\$14.00	
	82016		\$12.90	
	82017		\$18.60	
	82024		\$30.00	
	82030		\$34.00	
A	82040		\$1.80	
	82042		\$2.43	
	82043		\$4.30	
	82044		\$1.00	
	82055		\$4.50	
	82075		\$8.80	
	82085		\$11.00	
	82088		\$40.00	
	82101		\$16.30	
	82103		\$7.80	
	82104		\$7.80	

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp	IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp
	82105		\$10.20		N	82489		\$15.00	
	82106		\$10.20			82491		\$21.50	
	82108		\$28.17			82492		\$21.50	
	82120		\$4.00			82495		\$9.66	
	82127		\$12.90			82507		\$37.00	
	82128		\$12.90			82520		\$17.00	
	82131		\$18.64			82523		\$15.00	
	82135		\$20.00			82525		\$9.00	
	82136		\$18.64			82528		\$19.70	
	82139		\$18.64			82530		\$17.00	
	82140		\$6.00			82533		\$17.00	
	82143		\$4.20			82540		\$3.00	
	82145		\$12.00			82541		\$4.40	
A	82150		\$4.50			82542		\$21.50	
	82154		\$31.88			82543		\$21.50	
	82157		\$29.00			82544		\$21.50	
	82160		\$27.65		A	82550		\$4.80	
	82163		\$21.00			82552		\$7.80	
	82164		\$20.00			82553		\$7.50	
	82172		\$20.00			82554		\$16.00	
	82175		\$7.20		A	82565		\$3.00	
	82180		\$3.60			82570		\$3.00	
	82190		S.C.C.			82575		\$4.50	
	82205		\$12.00			82585		\$6.30	
	82232		\$17.80			82595		\$1.50	
	82239		\$20.00			82600		\$25.00	
	82240		\$5.69			82607		\$15.00	
	82247		\$3.00			82608		\$15.00	
	82248		\$4.50			82615		\$11.00	
	82252		\$2.50			82626		\$29.60	
	82261		\$18.64			82627		\$29.00	
	82270		\$1.20			82633		\$38.52	
	82273		\$3.70			82634		\$25.72	
	82274		\$3.70			82638		\$15.20	
	82286		\$7.60			82646		\$25.30	
	82300		\$28.00			82649		\$31.00	
	82306		\$30.00			82651		\$33.00	
	82307		\$25.00			82652		\$47.87	
	82308		\$34.00			82654		\$13.60	
A	82310		\$3.00			82657		\$21.50	
	82330		\$14.70			82658		\$21.50	
	82331		\$5.72			82664		\$13.60	
	82340		\$3.60			82666		\$22.00	
	82355		\$9.00			82668		\$17.50	
	82360		\$12.00			82670		\$25.00	
	82365		\$9.00			82671		\$41.00	
	82370		\$9.00			82672		\$25.00	
	82373		\$7.95			82677		\$28.00	
A	82374		\$3.30			82679		\$25.00	
	82375		\$6.00			82690		\$21.50	
	82376		\$3.00			82693		\$12.50	
	82378		\$22.40			82696		\$22.00	
	82379		\$18.64			82705		\$0.60	
	82380		\$6.00			82710		\$7.80	
	82382		\$12.00			82715		\$7.80	
	82383		\$12.00			82725		\$15.50	
	82384		\$18.00			82726		\$21.50	
	82387		\$24.00		N	82728		\$16.00	
	82390		\$6.00			82731		\$71.20	
	82397		\$19.50			82735		\$24.00	
	82415		\$15.00			82742		\$21.73	
A	82435		\$3.00			82746		\$10.50	
	82436		\$3.00			82747		\$18.00	
	82438		\$3.00			82757		\$22.50	
	82441		\$8.00			82759		\$11.50	
A	82465		\$3.00			82760		\$15.00	
	82480		\$4.50			82775		\$3.74	
	82482		\$10.00			82776		\$8.90	
	82485		\$28.00			82784		\$11.30	
	82486		\$4.40			82785		\$16.00	
N	82487		\$4.00			82787		\$11.09	
N	82488		\$15.00			82800		\$5.20	

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp	IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp
	82803		\$16.50		A	83540		\$4.50	
	82805		\$8.00		A	83550		\$7.20	
	82810		\$10.00			83570		\$6.00	
	82820		\$13.82			83582		\$6.00	
	82926		\$6.00			83586		\$7.50	
	82928		\$6.00			83593		\$6.00	
	82938		\$22.00			83605		\$13.50	
	82941		\$16.00		A	83615		\$4.20	
	82943		\$19.00			83625		\$9.00	
	82945		\$4.34			83632		\$16.00	
A	82946		\$13.00			83633		\$6.30	
	82947		\$4.34			83634		\$14.00	
	82948		\$1.50		N	83655		\$9.00	
	82950		\$3.00			83661		\$10.50	
	82951		\$5.00			83662		\$5.00	
	82952		\$1.00			83663		\$10.46	
	82953		\$10.00			83664		\$5.23	
	82955		\$6.00			83670		\$2.10	
	82960		\$7.00			83690		\$4.50	
	82962		\$2.60			83715		\$7.50	
	82963		\$26.50			83716		\$22.00	
	82965		\$6.30		A	83718		\$8.00	
	82975		\$19.80			83719		\$15.50	
A	82977		\$4.80			83721		\$10.00	
	82978		\$12.00			83727		\$17.00	
	82979		\$9.00		A	83735		\$4.50	
	82980		\$20.00			83775		\$5.90	
	82985		\$6.60			83785		\$12.99	
	83001		\$17.00			83788		\$4.40	
	83002		\$17.00			83789		\$4.40	
	83003		\$16.00			83805		\$23.00	
	83004		\$16.00			83825		\$8.40	
	83008		\$21.60			83835		\$10.20	
	83010		\$12.00			83840		\$4.50	
	83012		\$12.00			83857		\$12.00	
	83013		\$48.00			83858		\$19.80	
	83014		\$9.00			83864		\$13.00	
	83015		\$10.20			83866		\$12.00	
	83018		\$25.00			83872		\$3.20	
	83020		\$6.00			83873		\$20.00	
	83021		\$21.50			83874		\$12.00	
	83026		\$2.00			83880		\$37.80	
	83030		\$10.00			83883		S.C.C.	
	83033		\$7.00			83885		\$19.00	
	83036		\$6.60			83887		\$20.00	
	83045		\$1.50			83890		\$5.00	
	83050		\$3.00			83891		\$5.00	
	83051		\$1.20			83892		\$5.00	
	83055		\$1.50			83893		\$5.00	
	83060		\$3.00			83894		\$5.00	
	83065		\$3.00			83896		\$5.00	
	83068		\$3.00			83897		\$5.00	
	83069		\$3.00			83898		\$20.00	
	83070		\$6.00			83901		\$20.00	
	83071		\$9.00			83902		\$19.00	
	83080		\$19.20			83903		\$20.00	
	83088		\$40.00			83904		\$20.00	
	83090		\$18.65			83905		\$20.00	
	83150		\$12.00			83906		\$20.00	
	83491		\$12.60			83912		\$5.54	
	83497		\$6.00			83915		\$6.00	
	83498		\$30.50			83916		\$20.00	
	83499		\$30.50			83918		\$19.00	
	83500		\$30.00			83919		\$19.00	
	83505		\$30.00			83921		\$19.00	
	83516		\$9.00			83925		\$22.00	
	83518		\$8.00			83930		\$9.00	
	83519		\$15.00			83935		\$9.00	
	83520		S.C.C.			83937		\$40.00	
	83525		\$12.00			83945		\$17.00	
	83527		\$16.11			83950		\$71.20	
	83528		\$20.00			83970		\$54.00	

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp	IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp
	83986		\$4.30			84392		\$5.60	
	83992		\$18.00			84402		\$30.40	
	84022		\$20.00			84403		\$32.00	
	84030		\$6.00			84425		\$29.00	
	84035		\$4.90			84430		\$3.60	
	84060		\$3.60			84432		\$13.00	
	84061		\$3.60			84436		\$6.00	
	84066		\$12.60			84437		\$6.00	
A	84075		\$3.60			84439		\$10.00	
	84078		\$3.60			84442		\$12.00	
	84080		\$3.60			84443		\$23.00	
N	84081		\$20.00			84445		\$27.80	
	84085		\$7.90			84446		\$16.80	
	84087		\$13.50			84449		\$24.00	
A	84100		\$3.00		A	84450		\$3.00	
	84105		\$3.00		A	84460		\$3.00	
	84106		\$1.80			84466		\$15.20	
	84110		\$7.50		A	84478		\$7.30	
	84119		\$3.00			84479		\$6.00	
	84120		\$7.50			84480		\$15.00	
	84126		\$34.50			84481		\$15.00	
	84127		\$15.00			84482		\$15.00	
A	84132		\$3.90			84484		\$12.00	
	84133		\$3.90			84485		\$3.30	
	84134		\$20.00			84488		\$3.30	
	84135		\$12.00			84490		\$3.30	
	84138		\$12.00			84510		\$12.70	
	84140		\$27.50			84512		S.C.C.	
	84143		\$30.00		A	84520		\$3.00	
	84144		\$20.00			84525		\$3.00	
	84146		\$20.00			84540		\$3.00	
	84150		\$30.00			84545		\$6.00	
	84152		\$24.50		A	84550		\$3.00	
A	84153		\$24.50			84560		\$3.00	
	84154		\$24.50			84577		\$6.00	
	84155		\$1.80			84578		\$0.40	
	84156		\$1.80			84580		\$2.10	
	84157		\$1.80			84583		\$2.10	
	84160		\$1.80			84585		\$12.00	
	84165		\$6.00			84586		\$48.00	
	84181		\$20.00			84588		\$45.00	
	84182		\$23.50			84590		\$6.00	
N	84202		\$10.40			84591		\$12.82	
N	84203		\$3.00			84597		\$18.00	
	84206		\$19.00			84600		\$18.00	
	84207		\$32.00		N	84620		\$16.00	
	84210		\$12.80			84630		\$15.00	
	84220		\$13.00			84681		\$22.00	
	84228		\$13.60			84702		\$11.39	
	84233		\$16.00			84703		\$3.00	
	84234		\$20.00			84830		\$3.00	
	84235		\$63.20			84999		S.C.C.	
	84238		\$43.00			85002		\$1.20	
	84244		\$25.00			85004		\$7.20	
	84252		\$24.00		N	85007		\$2.40	
	84255		\$29.60			85008		\$1.20	
	84260		\$35.20			85009		\$1.20	
	84270		\$25.00			85013		\$1.50	
	84275		\$16.00		N	85014		\$1.50	
	84285		\$28.80		N	85018		\$1.20	
A	84295		\$3.90		N	85025		S.C.C.	
	84300		\$3.90		N	85027		\$4.80	
	84302		\$3.90			85032		\$3.00	
	84305		\$16.00		N	85041		\$1.20	
	84307		\$16.00			85044		\$3.00	
	84311		\$7.50			85045		\$4.00	
	84315		\$3.00			85046		\$2.75	
	84375		\$23.20		N	85048		\$1.20	
	84376		\$7.00		N	85049		\$5.00	
	84377		\$7.00			85055		\$38.00	
	84378		\$14.00			85060		S.C.C.	
	84379		\$14.00			85097		S.C.C.	

<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>	<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>
	85130		S.C.C.			85675		\$6.42	
	85170		\$0.60			85705		\$7.90	
	85175		\$3.90			85730		\$3.00	
	85210		\$3.00			85732		\$3.00	
	85220		\$24.00			85810		\$15.00	
	85230		\$24.00			85999		S.C.C.	
	85240		\$24.00			86000		\$0.90	
	85244		\$28.00			86001		\$4.00	
	85245		\$10.00			86003		\$4.00	
	85246		\$10.00			86005		\$4.16	
	85247		\$10.00			86021		\$9.00	
	85250		\$26.00			86022		\$9.00	
	85260		\$24.00			86023		\$15.00	
	85270		\$24.00			86038		\$7.80	
	85280		\$26.00			86039		\$15.00	
	85290		\$8.00			86060		\$3.60	
	85291		\$7.00			86063		\$1.20	
	85292		\$26.00			86077		S.C.C.	
	85293		\$26.00			86078		S.C.C.	
	85300		\$15.00			86079		S.C.C.	
	85301		\$14.00			86140		\$3.00	
	85302		\$16.00			86141		\$14.30	
	85303		\$18.00			86146		\$35.00	
	85305		\$16.00			86147		\$35.00	
	85306		\$18.00			86148		\$22.00	
	85307		\$18.00			86155		\$14.00	
	85335		\$10.00			86156		\$3.00	
	85337		\$10.00			86157		\$9.00	
	85345		\$1.80			86160		\$9.00	
	85347		\$3.00			86161		\$9.00	
	85348		\$1.20			86162		\$15.60	
	85360		\$11.00			86171		\$4.50	
	85362		\$3.00			86185		\$7.90	
	85366		\$8.00			86215		\$18.00	
	85370		\$5.00			86225		\$13.00	
	85378		\$5.00			86226		\$15.00	
	85379		\$5.00			86235		\$24.00	
	85380		\$5.00			86243		\$15.90	
	85384		\$9.60			86255		\$7.80	
	85385		\$9.60			86256		\$12.50	
	85390		\$7.00			86277		\$16.00	
	85396		\$18.00			86280		\$5.40	
	85400		\$9.00			86294		\$12.00	
	85410		\$9.00			86300		\$23.00	
	85415		\$10.00			86301		\$23.00	
	85420		\$9.00			86304		\$23.00	
	85421		\$14.00			86308		\$3.00	
	85441		\$5.00			86309		\$5.00	
	85445		\$5.00			86310		\$4.50	
	85460		\$9.40			86316		\$28.00	
	85461		\$9.00			86317		\$8.00	
	85475		\$10.00			86318		\$7.00	
	85520		\$7.97			86320		\$10.50	
	85525		\$16.00			86325		\$25.00	
	85530		\$16.00			86327		\$25.00	
	85536		\$5.00			86329		\$19.00	
	85540		\$8.90			86331		\$4.50	
	85547		\$10.50			86332		\$33.00	
	85549		\$25.00			86334		\$30.00	
	85555		\$4.80			86336		S.C.C.	
	85557		\$4.80			86337		\$13.71	
	85576		\$10.00			86340		\$20.00	
	85597		\$20.00			86341		\$25.00	
	85610		\$3.00			86343		\$6.00	
	85611		\$4.50			86344		\$10.86	
	85612		\$13.00			86353		\$32.00	EACH MITOGEN
	85613		\$10.00			86359		\$40.00	
	85635		\$8.40			86360		\$55.00	
	85651		\$1.50			86361		\$55.00	
	85652		\$1.50			86376		\$6.60	
	85660		\$3.00			86378		\$26.00	
	85670		\$6.60			86382		\$20.00	

<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>	<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>
	86384		\$10.86			86727		\$15.00	
	86403		\$8.00			86729		\$12.00	
	86406		\$6.60			86732		\$15.00	
	86430		\$1.80			86735		\$15.00	
	86431		\$4.50			86738		\$12.00	
	86485		S.C.C.			86741		\$12.00	
	86490		S.C.C.			86744		\$12.00	
	86510		S.C.C.			86747		\$12.00	
	86580		S.C.C.			86750		\$12.00	
	86585		S.C.C.			86753		\$12.00	
	86586		S.C.C.			86756		\$12.00	
	86590		\$8.00			86757		\$21.40	
	86592		\$1.50			86759		\$12.00	
	86593		\$3.00			86762		\$12.00	
	86602		\$10.00			86765		\$10.00	
	86603		\$10.00			86768		\$12.00	
	86606		\$10.00			86771		\$12.00	
	86609		\$10.00			86774		\$5.40	
	86611		\$11.20			86777		\$12.00	
	86612		\$10.00			86778		\$15.00	
	86615		\$10.00			86781		\$12.00	
	86617		\$19.00			86784		\$8.00	
	86618		\$23.00			86787		\$12.60	
	86619		\$10.00			86790		S.C.C.	
	86622		\$8.00			86793		\$8.00	
	86625		\$10.00			86800		\$13.00	
	86628		\$10.00			86803		\$19.00	
	86631		\$10.00			86804		\$20.00	
	86632		\$15.00			86805		\$22.00	
	86635		\$10.00			86806		\$22.00	
	86638		\$12.50			86807		\$54.00	
	86641		\$12.50			86808		\$39.00	
	86644		\$12.00			86812		\$12.60	
	86645		\$12.00			86813		\$19.00	
	86648		\$18.00			86816		\$19.00	
	86651		\$12.00			86817		\$19.00	
	86652		\$12.00			86821		\$68.00	
	86653		\$12.00			86822		\$50.00	
	86654		\$12.00			86849		S.C.C.	
	86658		\$12.00			86850		\$4.20	
	86663		\$12.00			86860		\$4.20	
	86664		\$21.00			86870		\$9.00	
	86665		\$25.00			86880		\$5.00	
	86666		\$11.20			86885		\$6.80	
	86668		\$12.00			86886		\$5.00	
	86671		\$15.00			86890		\$75.00	
	86674		S.C.C.			86891		\$75.00	
	86677		\$12.00			86900		S.C.C.	
	86682		\$12.00			86901		S.C.C.	
	86684		\$15.00			86903		S.C.C.	
	86687		\$11.60			86904		S.C.C.	
	86688		\$13.00			86905		\$3.00	
	86689		\$21.20			86906		\$2.00	
	86692		\$20.00			86910		\$12.60	
	86694		\$12.80			86911		\$5.00	
	86695		\$12.80			86920		S.C.C.	
	86696		\$21.40			86921		S.C.C.	
	86698		\$15.00			86922		S.C.C.	
	86701		\$12.00			86940		\$9.50	
	86702		\$13.00			86941		\$12.50	
	86703		\$18.00			86945		S.C.C.	
	86704		\$15.00			86950		S.C.C.	
	86705		\$12.60			86965		S.C.C.	
	86706		\$12.00			86970		S.C.C.	
	86707		\$12.00			86971		S.C.C.	
	86708		\$12.00			86972		S.C.C.	
	86709		\$12.60			86975		S.C.C.	
	86710		\$12.00			86976		S.C.C.	
	86713		\$20.00			86977		S.C.C.	
	86717		\$16.00			86978		S.C.C.	
	86720		\$15.00			86985		S.C.C.	
	86723		\$15.00			86927		S.C.C.	

<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>	<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Office Total Fee</u>	<u>Maximum Fee Allowance \$ Prof. Comp</u>
	86930		S.C.C.			87277		\$12.18	
	86931		S.C.C.			87278		\$15.00	
	86932		S.C.C.			87279		\$12.18	
	86999		S.C.C.			87280		\$12.00	
	87001		\$9.00			87281		\$12.18	
	87003		\$15.00			87283		\$12.18	
	87015		\$5.10			87285		\$12.00	
N	87040		\$9.00			87290		\$12.60	
N	87045		\$9.00			87299		\$12.00	
N	87046		\$3.00			87300		\$6.00	
N	87070		\$9.00			87301		\$12.00	
	87071		\$6.00			87320		\$12.50	
	87073		\$6.00			87324		\$12.50	
	87075		\$9.00			87327		\$12.18	
	87076		\$6.00			87328		\$12.50	
	87077		\$9.00			87329		\$12.00	
N	87081		\$9.00			87332		\$12.00	
	87084		\$3.00			87335		\$12.00	
	87086		\$6.00			87336		\$12.18	
	87088		\$2.70			87337		\$12.18	
	87101		\$8.00			87338		\$9.00	
	87102		\$8.00			87339		\$12.18	
	87103		\$8.00			87340		\$14.00	
	87106		\$8.00			87341		\$11.42	
	87107		\$11.42			87350		\$14.00	
	87109		\$14.00			87380		\$20.00	
	87110		\$15.00			87385		\$15.00	
	87116		\$6.00			87390		\$15.00	
	87118		\$12.00			87391		\$15.00	
	87140		\$3.00			87400		\$6.00	
	87143		\$3.00			87420		\$12.00	
	87147		\$3.00			87425		\$12.00	
	87149		\$22.00			87427		\$12.18	
	87152		\$5.79			87430		\$12.00	
	87158		\$3.00			87449		\$12.00	
	87164		\$6.00			87450		\$10.00	
	87166		\$6.00			87451		\$10.60	
	87168		\$4.72			87470		\$20.00	
	87169		\$4.72			87471		\$30.00	
	87172		\$4.72			87472		\$20.00	
	87176		\$6.40			87475		\$25.00	
	87177		\$5.10			87476		\$38.00	
	87181		\$5.80			87477		\$20.00	
N	87184		\$9.00			87480		\$25.00	
	87185		\$5.25			87481		\$38.00	
	87186		\$11.00			87482		\$20.00	
	87187		\$13.00			87485		\$25.00	
	87188		\$6.00			87486		\$38.00	
	87190		\$0.60			87487		\$20.00	
	87197		\$15.00			87490		\$20.00	
	87205		\$4.20			87491		\$38.00	
	87206		\$4.20			87492		\$20.00	
	87207		\$3.00			87495		\$25.00	
	87210		\$2.40			87496		\$38.00	
	87220		\$2.40			87497		\$20.00	
	87230		\$27.00			87510		\$25.00	
	87250		\$25.50			87511		\$28.00	
	87252		\$29.50			87512		\$20.00	
	87253		\$6.00			87515		\$25.00	
	87254		\$5.41			87516		\$38.00	
	87255		\$30.00			87517		\$20.00	
	87260		\$10.00			87520		\$25.00	
	87265		\$10.00			87521		\$38.00	
	87267		\$10.00			87522		\$20.00	
	87269		\$10.00			87525		\$25.00	
	87270		\$10.00			87526		\$38.00	
	87271		\$10.00			87527		\$20.00	
	87272		\$12.00			87528		\$25.00	
	87273		\$12.18			87529		\$38.00	
	87274		\$12.80			87530		\$20.00	
	87275		\$12.18			87531		\$25.00	
	87276		\$12.00			87532		\$38.00	

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp	IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp
	87533		\$20.00			88167		\$6.00	
	87534		\$25.00			88172		S.C.C.	
	87535		\$38.00			88173		S.C.C.	
	87536		\$117.00			88174		\$23.50	
	87537		\$25.00			88175		\$28.50	
	87538		\$38.00			88180		S.C.C.	
	87539		\$20.00			88182		\$300.00	
	87540		\$25.00			88199		S.C.C.	
	87541		\$38.00			88230		\$90.00	
	87542		\$20.00			88233		\$90.00	
	87550		\$25.00			88235		\$90.00	
	87551		\$38.00			88237		\$90.00	
	87552		\$20.00			88239		\$90.00	
	87555		\$25.00			88240		\$7.75	
	87556		\$38.00			88241		\$7.75	
	87557		\$20.00			88245		\$184.00	
	87560		\$25.00			88248		\$230.00	
	87561		\$38.00			88249		\$230.00	
	87562		\$20.00			88262		\$172.00	
	87580		\$25.00			88263		\$184.00	
	87581		\$38.00			88264		\$172.00	
	87582		\$20.00			88267		\$230.00	
	87590		\$25.00			88271		\$16.00	
	87591		\$38.00			88273		\$35.00	
	87592		\$20.00			88274		\$45.00	
	87620		\$25.00			88275		\$55.00	
	87621		\$38.00			88280		\$34.00	
	87622		\$20.00			88283		\$46.00	
	87650		\$25.00			88285		\$27.23	
	87651		\$38.00			88289		\$40.00	
	87652		\$20.00			88291		\$26.82	
	87660		\$25.00			88300		S.C.C.	
	87797		\$25.00			88302		S.C.C.	
	87798		\$38.00			88304		S.C.C.	
	87799		\$20.00			88305		S.C.C.	
	87800		\$25.00			88307		S.C.C.	
	87801		\$38.00			88309		S.C.C.	
	87802		\$12.17			88311		S.C.C.	
	87803		\$12.17			88312		S.C.C.	
	87804		\$12.17			88313		S.C.C.	
	87810		\$12.00			88314		S.C.C.	
	87850		\$12.00			88318		S.C.C.	
	87880		\$12.00			88319		S.C.C.	
	87899		\$12.00			88321		S.C.C.	
	87901		\$350.00			88323		S.C.C.	
	87903		\$675.72			88325		S.C.C.	
	87904		\$36.00			88329		S.C.C.	
	87999		S.C.C.			88331		S.C.C.	
	88104		S.C.C.			88332		S.C.C.	
	88106		S.C.C.			88342		S.C.C.	
	88107		S.C.C.			88346		\$40.00	
	88108		S.C.C.			88347		\$45.00	
	88112		\$18.00		N	88348		\$184.00	
	88125		S.C.C.		N	88349		S.C.C.	
	88130		\$9.65			88355		S.C.C.	
	88140		\$4.20			88356		S.C.C.	
	88141		\$6.00			88358		S.C.C.	
	88142		\$18.00			88361		\$94.00	
	88143		\$18.00			88362		S.C.C.	
	88147		\$13.48			88365		\$47.25	
	88148		\$13.48			88371		\$30.00	
	88150		\$6.00			88372		S.C.C.	
	88152		\$6.00			88380		S.C.C.	
	88153		\$6.00			88399		S.C.C.	
	88154		\$6.00			88400		\$3.00	
N	88155		\$6.00			89050		\$0.90	
	88160		S.C.C.			89051		\$0.90	
	88161		S.C.C.			89055		\$4.76	
	88162		S.C.C.			89060		\$8.50	
	88164		\$6.00			89100		S.C.C.	
	88165		\$6.00			89105		S.C.C.	
	88166		\$6.00			89125		\$0.60	

IND	HCPCS Code	Mod	Office Total Fee	Maximum Fee Allowance \$ Prof. Comp
	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	
	89205		\$1.20	
	89220		\$8.00	
	89225		\$4.50	
	89230		\$9.00	
	89310		\$4.80	
	89320		\$9.00	
	89321		\$9.00	
	89325		\$13.00	

Amended by R.2002 d.323, effective October 7, 2002.
 See: 34 N.J.R. 959(a), 34 N.J.R. 3524(a).
 Added HCPCS Code 82731 and its corresponding Office Total Fee.
 Amended by R.2003 d.15, effective January 6, 2003.
 See: 34 N.J.R. 2676(a), 35 N.J.R. 230(c).
 Updated the table of HCPCS procedure codes.
 Repeal and New Rule, R.2005 d.214, effective July 5, 2005.
 See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).
 Section was "HCPCS procedure codes and maximum fee allowance schedule for pathology/laboratory".

10:52-10.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT)

PATHOLOGY/LABORATORY

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
	G0027		Semen analysis; presence and/or motility of sperm excluding Huhner test	2.40
	G0141		Screening cytopathology smears, cervical or vaginal performed by automated system, with manual rescreening requiring interpretation by physician	10.00
	G0306		Complete CBC, automated (HGB, HCT, RBC, WBC, without platelet count) and automated WBC differential count	5.00
	G0307		Complete CBC, automated (HGB, HCT, RBC, WBC, without platelet count)	4.80
	G0328		Colorectal cancer screening; fecal-occult blood test, immunoassay, 1-3 simultaneous determinations	7.00
	P3000		Screening Papanicolaou smear, cervical or vaginal, up to three smears; by technician under physician supervision	6.00
	P3001		Requiring interpretation by physician	6.00
	P9031		Platelets, leukocytes reduced, each unit	S.C.C.

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
	P9032		Platelets, irradiated, each unit	S.C.C.
	P9033		Platelets, leukocytes reduced, irradiated, each unit	S.C.C.
	P9034		Platelets, pheresis, each unit	S.C.C.
	P9040		Red blood cells, leukocytes reduced, irradiated, each unit	S.C.C.
	P9041		Infusion, albumin (human), 5%, 50ml	S.C.C.
	P9043		Infusion, plasma protein fraction (human), 5%, 50ml	S.C.C.
	P9044		Plasma, cryoprecipitate reduced, each unit	S.C.C.
	P9046		Infusion, albumin (human), 25%, 20ml	S.C.C.
	P9604		Prorated trip charge	1.38
	P9612		Catheterization for collection of urine; all places of service	1.80
	P9615		Catheterization for collection of (urine) specimen(s), (multiple) patients	1.80

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.

Q0111 Wet mount, including preparations of vaginal, cervical or skin specimens

Q0112 All potassium hydroxide (KOH) preparations

Q0113 Pinworm examination

Q0114 Fern test

Q0115 Post-coital direct, qualitative examinations of vaginal or cervical mucous

W8900 Visits to homebound beneficiaries, residential health care facility, group home, or boarding home for purpose of obtaining blood by venous or arterial puncture

Amended by R.2000 d.29, effective January 18, 2000.
 See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
 In the table, deleted a reference to home bound, nursing and SNF patients in P9610, and deleted W8900, W8920 and W8925.
 Amended by R.2005 d.214, effective July 5, 2005.
 See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).
 Added HCPCS codes G0027, G0141, G0306, G0307, G0328, P3000, P3001, P9031 through P9034, P9040, P9041, P9043, P9044, P9046, P9604, P9612 and W8900; deleted HCPCS codes G0001, P9610, Q0116, W8200, W8260, W8265, and W8730.

10:52-10.4 Pathology and Laboratory HCPCS Codes—Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Organ or Disease Oriented Laboratory Panels

NOTE: The following calculations and ratios are not eligible for separate or additional reimbursement.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

2. Codes 80048, 80050, 80051, 80053, 80055, 80061, 80069, 80074 and 80076. The panels listed must include the laboratory tests assigned by the CPT 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 or NJ FamilyCare fee-for-service program 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.

3. Codes 82487, 82488, and 82489—Chromatography—must list substance (compound) tested for in block 34 (REMARKS) of the claim form.

4. 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).

5. Code 84620—Xylose absorption tests, blood and/or urine (D-xylose tolerance test), includes serum & urine levels, up to 5 hourly specimens.

6. Codes 85025 and 85027—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.

Hematology codes 85014, 85018, 85041 and 85048 may not be reimbursed in conjunction with codes for blood count with hemogram (85025, and 85027).

The code for manual differential WBC count (85007) may not be reimbursed in conjunction with codes 85025, and 85027.

Codes for platelet count 85049 may not be reimbursed in conjunction with codes 85025 and 85027.

7. Codes 87040, 87045, 87070, 87184—Cultures

NOTE: These codes may only be reimbursed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture; (87081).

8. Code 88155—Pap smear

NOTE: Obtaining specimen not a separate eligible service.

9. Code 88348 and 88349—Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

NOTE: For reimbursement purposes, the Medicaid and NJ FamilyCare fee-for-service programs will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, that is, gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

10. 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.

11. Code W8900—This Code may be used only once per trip, regardless of the number of beneficiaries seen, and requires a distance in excess of 20 miles per round trip.

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

In (a), inserted references to NJ KidCare fee-for-service programs in 2 and 11, and substituted a reference to CPT for a reference to CPT-4 in 2.

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

Rewrote the section.

10:52-10.5 Pathology and Laboratory HCPCS Codes—Modifiers

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance has been identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid and NJ FamilyCare fee-for-service programs' recognized modifier codes are:

<u>Modifier Code</u>	<u>Description</u>
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.

<u>Modifier Code</u>	<u>Description</u>
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.

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

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

In (a), inserted a reference to NJ KidCare fee-for-service programs. Amended by R.2005 d.214, effective July 5, 2005.

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

In (a), substituted "FamilyCare" for "KidCare" in the introductory paragraph.

SUBCHAPTER 11. CHARITY CARE

10:52-11.1 Charity care audit functions

(a) The Department of Health and Senior Services shall conduct an audit of disproportionate share hospitals' charity care reported as written-off each calendar year. The Department of Health and Senior Services shall audit charity care at least once, but no more than six times each calendar year.

(b) The Department of Health and Senior Services shall report to the Division of Medical Assistance and Health Services on charity care. This report shall include any adjustments made pursuant to N.J.A.C. 10:52-11.15 or 13.4 or approvals made pursuant to N.J.A.C. 10:52-11.8(c) and (d).

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

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

In (b), substituted "report to the Division of Medical Assistance and Health Services" for "make a monthly report to the Essential Health Services Commission" in the first sentence, and changed N.J.A.C. references in the second sentence.

Amended by R.2003 d.485, effective December 15, 2003.

See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

In (a), substituted "disproportionate share" for "acute care" preceding "hospitals' charity"; in (b), amended N.J.A.C. references.

10:52-11.2 Sampling methodology

(a) The Department of Health and Senior Services shall audit charity care claims based on a sample which will be developed from the charity claims submitted for pricing as described in N.J.A.C. 10:52-12.2.

(b) The Department of Health and Senior Services shall require hospitals to make a small number of additional charity care accounts available upon audit.

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

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

Rewrote (a); and deleted a former (c).

10:52-11.3 Charity care write off amount

(a) The Department of Health and Senior Services shall value charity care claims at the Medicaid rate. The Medicaid rate, for purposes of valuing a given charity care claim, shall be based on the New Jersey Medicaid program's pricing and program policies pursuant to N.J.A.C. 10:52-12.1 and 12.2. 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. 10:52-11.8(b) and (c) multiplied by the Medicaid payment rate.

2. In the event that there is a partial payment from a third party, the charity care write-off amount is determined as follows: Charity Care Write Off Amount equals Medicaid payment rate minus third party payment multiplied by Charity Care Eligibility Percentage. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to all Federal disproportionate share rules, including the Omnibus Budget Reconciliation Act of 1993, Section 13621.

3. If the third party payment is greater than the Medicaid payment rate, the charity care write-off amount shall be listed as zero.

(b) Applicants eligible for charity care at 100 percent shall not be billed. Any difference between hospital charges and the Medicaid rate shall be recorded as a contractual allowance.

(c) Applicants eligible for charity care at less than 100 percent shall be billed as follows:

1. Applicant Responsibility equals 100 percent minus Charity Care Eligibility Percentage multiplied by Hospital Charges minus any third party payment.

2. Contractual allowance equals Hospital Charges minus any third party payment minus Charity Care Write Off plus Applicant Responsibility.

(d) The Department of Health and Senior Services will calculate the cost of charity care services at the rate that would have been paid by the New Jersey Medicaid program.

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

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

In (a)1, changed N.J.A.C. reference; and in (d), substituted a reference to the Department of Health and Senior Services for a reference to the Essential Health Services Commission.

Amended by R.2000 d.299, effective July 17, 2000.

See: 32 N.J.R. 1123(a), 32 N.J.R. 2615(a).

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

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

Amended by R.1994 d.432, effective August 15, 1994.
 See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).
 Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).
 See: 26 N.J.R. 3485(a).
 Petition for Rulemaking.
 See: 26 N.J.R. 3756(a).
 Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.
 See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).
 Amended by R.1995 d.13, effective January 3, 1995.
 See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).
 Petition for Rulemaking.
 See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).
 Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).
 See: 28 N.J.R. 4115(a).
 Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.
 See: 28 N.J.R. 4115(a), 28 N.J.R. 4805(c).
 Amended by R.1997 d.92, effective February 18, 1997.
 See: 28 N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).
 In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.
 Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).
 See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).
 Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.
 Amended by R.1998 d.340, effective July 6, 1998.
 See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).
 In (a), rewrote 2 and 4, and deleted a former 6.
 Recodified from 10:52-8.2(a)5 and amended by R.2000 d.29, effective January 18, 2000.
 See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
 Made internal designation changes throughout.
 Amended by R.2005 d.214, effective July 5, 2005.
 See: 37 N.J.R. 436(a), 37 N.J.R. 2506(a).

In (a), inserted "(DMHS)" following "Division of Mental Health Services" in the introductory paragraph, substituted "STCF" for "STF" preceding "and CCIS" and rewrote the last sentence in 1i, and rewrote the last sentence in 1ii.

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

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

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

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

2. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined, based on the most recent available complete calendar year UB data maintained by the Department of Health and Senior Services (DHSS), as follows:

- i. Rank zip codes from highest to lowest, based on the percentage of total admissions drawn from each zip code by the closed hospital; and

- ii. Include the ranked zip codes in the closed hospital's market area (beginning with the highest-

ranked zip code) until the percentage of admissions, when added together, constitutes 75 percent of the closed hospital's total admissions; and

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

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

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

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

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

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

ii. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market

area served by the closed hospital shall be determined as defined in (b)2 above; and

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

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

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

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

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

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

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

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

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

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

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

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

Rewrote the section.

SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

10:52-14.1 Effective date

(a) Effective for inpatient services with discharge dates on or after August 3, 2009, general acute care hospitals will be

10:52-14.14 Payment for transfers

(a) When a patient is transferred during a covered general acute care hospital inpatient stay from one hospital to another hospital, the reimbursement to the general acute care hospitals involved in the transfer(s) will be calculated as follows:

1. The reimbursement to each transferring general hospital will be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital will be no greater than the standard DRG payment, except where the transferring hospital is eligible for an outlier payment;
2. The receiving acute care general hospital will be reimbursed the standard DRG payment. If the claim qualifies as an outlier, the receiving hospital will be eligible for outlier payments based solely on the stay at the receiving hospital; and
3. Transfer cases, both transferring and receiving, that are cost or day outliers shall be subject to the Division's utilization review to determine whether the outlier payment is medically necessary.

10:52-14.15 Payment for same day discharges

In cases where the patient has been admitted and is discharged on the same day, reimbursement will be paid at the DRG daily rate.

10:52-14.16 Payment for readmissions

(a) For New Jersey hospitals, where a patient is readmitted to the same hospital for the same or similar diagnosis within seven days, the second claim submitted for payment will be denied. The same or similar principal diagnosis is defined as principal diagnoses with the same first three digits in accordance with the International Classification of Diseases, 9th Edition, Clinical Modification published by Practice Management Information Corporation. For these readmissions, the two hospital inpatient stays shall be combined on the same claim form for reimbursement purposes.

(b) The denial and subsequent combination of claims specified in (a) above may be appealed by following the process specified in (b)1 through 3 below.

1. For a hospital with non-delegated utilization review, the hospital shall request an appeal through its QIO. Hospitals that are delegated for utilization review shall request an appeal through the hospital's appeal process and obtain a final appeal decision from its Physician Advisor (PA).
2. An appeal that is approved by the QIO or PA shall be submitted to the Division's fiscal agent, along with a letter from the hospital's QIO or PA, on the QIO's or hospital's letterhead, with a determination that the two hospital stays should not be combined, including the reason supporting its determination, along with an original signature of the hospital's Physician Advisor or QIO Physician Advisor.

i. The letter from the QIO or PA shall also include the beneficiary's name, Medicaid identification number, dates of service for the paid and denied claims and the hospital's Medicaid provider number.

ii. The discharge summary shall be provided for both the paid and denied claims. For stays less than 48 hours, progress notes may be used in lieu of discharge summaries.

3. The Division's fiscal agent will forward appeals that meet the requirements in (b)1 and 2 above to the Division's Office of the Medical Director. Each admission will be evaluated by New Jersey licensed physicians on a case-by-case basis to determine whether the admission and readmission to the same hospital should be combined.

(c) The requirements in (a) and (b) above apply to New York hospitals for readmissions within 30 days and apply to Pennsylvania hospitals for readmissions within 31 days. New York and Pennsylvania appeal requests shall be mailed to:

Division of Medical Assistance and Health
Services
Attention: Hospital Discharge/Readmit Appeals
Mail Code #44
P.O. Box 712
Building 7, Room 302
Trenton, NJ 08625-0712

10:52-14.17 Appeal of the hospital's Medicaid final rate

(a) For the purposes of submitting and adjudicating calculation error and rate appeals, a hospital may designate an individual or firm to represent it. This designation shall be in writing, signed by the chief executive officer of the hospital, and shall contain the representative's name, address and telephone number. This written notification shall be sent to the Division's Office of Reimbursement.

(b) Each hospital, within 15 working days of receipt of its Medicaid inpatient rate package, including its final rate and applicable add-on amounts, shall notify the Division of any calculation errors in its final rate. For years after the initial year that rates are set under this system, and for which no recalibration or rebasing has occurred, only calculation errors that relate to adjustments that have been made to the rates since the previously announced schedule of rates shall be permitted. For subsequent years, calculation error appeals will be limited to the mathematical accuracy or data used for recalibration, rebasing or both. Calculation errors are defined as mathematical errors in the calculations, or data not matching the actual source documents used to calculate the DRG weights and rates as specified in this subchapter. Hospitals shall not use the calculation error appeal process to revise data used to calculate the DRG weights and rates. Calculation error appeals that challenge the methodology used to calculate DRG weights and rates shall not be adjudicated as calculation error appeals, but hospitals are permitted to file such appeals as rate appeals delineated in (c) below. If upon

review it is determined by the Division that the error would constitute at least a one percent change in the hospital's final rate, a revised final rate will be issued to the hospital within 10 working days. If the discrepancy meets the one percent requirement above and a revised Schedule of Rates is not issued by the Division within 10 working days, notification time frames to appeal calculation errors noted above will not become effective until the hospital receives a revised Schedule of Rates. The Division will issue a written decision regarding all calculation error appeal issues timely submitted in accordance with (d) below.

(c) Any hospital, which seeks an adjustment to its final rate shall submit a rate appeal request.

1. A hospital shall notify the Division in writing of its intent to submit a rate appeal. The notice of appeal shall be submitted to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Hospital Reimbursement, Mail Code #44, PO Box 712, Trenton, New Jersey 08625-0712 within 20 calendar days of receipt by the hospital of its Medicaid inpatient final rate, including applicable add-on amounts.

2. A hospital shall identify its rate appeal issues and submit supporting documentation in writing to the Division within 80 calendar days of receipt by the hospital of its Medicaid inpatient final rate, including applicable add-on amounts.

3. In order to be considered a valid rate appeal, the hospital's submission shall meet the following requirements:

- i. A detailed description of the rate appeal issue shall be provided, including, but not limited to, the basis of the issue, such as whether certain portions of the Division's rate setting methodology are being challenged; and
- ii. Detailed calculations showing the financial impact of the rate appeal issue on the hospital's final rate and its estimated impact on the hospital's Medicaid inpatient reimbursement for the rate year.

4. If the Division finds the rate appeal issue to have merit, a financial review shall be undertaken by the Division to determine whether the hospital is efficiently operated in order to qualify for a rate adjustment. The financial review shall include, but not be limited to, the following:

- i. Financial ratios;
- ii. Efficiency indexes;
- iii. Occupancy and length of stay;
- iv. Debt structure;
- v. Changes in cost, revenue and services;
- vi. Analysis of the hospital's audited financial statements, including all related entities; and

vii. Comparison to appropriate state and national norms.

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

(e) The Division shall issue a written determination with an explanation as to each calculation error appeal, or request for a rate adjustment. If a hospital is not satisfied with the Division's determination, the hospital may request an Office of Administrative Law (OAL) hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an OAL 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, rejecting or remanding the Administrative Law Judge's initial decision. Thereafter, review may be had in the Appellate Division of New Jersey Superior Court.

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

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

UNISYS
PO Box 4801
Trenton, New Jersey 08619-4801

or contact:

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

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

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

APPENDIX B
EMC MANUAL

AGENCY NOTE: The Electronic Media Claims (EMC) Manual is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the EMC Manual, replacement text will be distributed to providers and copies will be filed with the Office of Administrative Law. The EMC Manual may be re-

viewed and downloaded by accessing the following website: www.njmmis.com. For a paper copy of the EMC Manual, write to:

Unisys
PO Box 4801
Trenton, NJ 08619-4801

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