CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D–7 and 12.

Source and Effective Date

R.2000 d.29, effective December 21, 1999.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).

Executive Order No. 66(1978) Expiration Date

Chapter 52, Hospital Services Manual, expires on December 21, 2004.

Chapter Historical Note

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

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

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

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

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

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

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

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Subchapter 3, Teleprocessing Procedures, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), were repealed, and Subchapter 1, General Provisions, Subchapter 2, Policies and Procedures Related to Specific Services, Subchapter 3, Healthstart—Maternity and Pediatric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

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

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

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

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

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 3. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES

SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

SUBCHAPTER 1. GENERAL PROVISIONS

10:52–1.1 Purpose and scope

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

(b) Unless otherwise stated, the rules of this chapter apply to Medicaid and NJ KidCare–Plan A, B and C fee-for-service beneficiaries and to Medicaid and NJ KidCare–Plan A, B, C and D fee-for-service services which are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services which are to be provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO.

Petition for Rulemaking.
See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).
Amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
In (a), substituted a reference to Medicaid and NJ KidCare fee-for service beneficiaries for a reference to Medicaid recipients, and substituted a reference to psychiatric hospitals for a reference to private psychiatric hospitals; and added (b).

10:52–1.2 Definitions

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

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

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

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

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

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

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

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid and NJ KidCare–Plan A beneficiaries under 21 years of age or age 19 for NJ KidCare–Plan A for the purpose of assessing a beneficiary's health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

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

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

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

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

"Hospital" means, pursuant to section 1861(e) of the Social Security Act (42 U.S.C. § 1395x(e)), an institution which is primarily engaged in providing the following services to inpatients, by or under the supervision of physicians:

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

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

3. Maintains clinical records on all patients;

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

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

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

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

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

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

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

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

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

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

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

1. Certification for the admission of a beneficiary: For an individual who is a beneficiary when admitted to a facility or program, certification must be made by an independent team, as described under (c) above.

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

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

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

1. The Plan of Care (PoC) shall:

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

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

iii. State treatment objectives;

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

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

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

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

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

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

1. The individual PoC as described under 42 CFR 441.156, shall be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the psychiatric hospital.

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

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

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.

10:52–1.17 Utilization control; outpatient psychiatric services

(a) The following policies and procedures in this rule were developed to help ensure the appropriate utilization of outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a PoC, performance of periodic reviews for evaluation purposes, and supportive documentation for services rendered. Outpatient psychiatric services include the initial evaluation; individual psychotherapy; group psychotherapy; family therapy; family conference; partial hospitalization (see N.J.A.C. 10:52–2.10); psychological testing; and medication management.

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

1. An intake evaluation shall be performed within 14 days or by the third outpatient visit, whichever is later, for each Medicaid 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 policy for the evaluation team shall be as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. For services requiring prior authorization, such as partial hospitalization (see N.J.A.C. 10:52–2.11), a departure from the PoC requires a new request for prior authorization when a change in the patient's clinical condition necessitates an increase in the frequency and intensity of services, or change in the type of services which will exceed the services authorized.

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

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

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

ii. The appropriateness of the services being furnished; and

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

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

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

SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

10:52–2.1 Ambulatory Surgical Center (ASC)

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

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

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

10:52–13.1 Disproportionate share adjustment—general eligibility

(a) A disproportionate share hospital (DSH) shall be a hospital designated as such by the Commissioner of the Department of Human Services. At a minimum, each hospital with a Medicaid inpatient hospital utilization rate that is one standard deviation above the mean Medicaid utilization rate for hospitals receiving Medicaid payments in the State, and every hospital with a low-income utilization rate above 25 percent will be treated as a disproportionate share hospital.

(b) The Commissioner of the Department of Human Services may designate additional hospitals as disproportionate share hospitals if it is determined they serve a large number of low-income mentally ill or developmentally disabled clients.

(c) The Commissioner of the Department of Human Services may make additional disproportionate share payments to facilities operating under N.J.S.A. 18A:64G–1 et. seq. providing a high level of charity and uncompensated care to low-income persons and persons with special needs.

(d) The Commissioner of the Department of Human Services may also designate a hospital as eligible for additional disproportionate share payments if it is determined that the hospital provides a high percentage of care (as defined in N.J.A.C. 10:52–13.5) in proportion to total operating revenue to patients with HIV, mental illness, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse. In addition, to be designated as eligible for this additional disproportionate share payment, the facility shall have a high Charity Care plus Medicaid utilization rate (as defined in N.J.A.C. 10:52–13.5). A facility shall further demonstrate a commitment to the establishment and operation of a managed care program for the uninsured and other low-income persons.

Amended by R.1997 d.92, effective February 18, 1997.
See: N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).
Substantially amended (d).
Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).
In (a), deleted the third sentence.
Recodified from 10:52–8.1 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 (d) changed N.J.A.C. references throughout, and substituted a reference to complex neonates, HIV as a secondary diagnosis and mothers with substance abuse for a reference to neonatal complexity at the end of the first sentence.

10:52–13.2 Disproportionate share hospital (DSH) payment—general

The disproportionate share adjustment shall include an adjustment amount annually determined, as to N.J.A.C. 10:52–13.4, by the Commissioner, Department of Health and Senior Services in consultation with the Commissioner, Department of Human Services and, as to N.J.A.C. 10:52–13.3, 13.5, 13.6 and 13.7 by the Commissioner, Department of Human Services based upon a determination regarding payments for charity care. The annual DSH payments shall be calculated and distributed in accordance with all applicable Federal laws and regulations.

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) and amended by R.2000 d.29, effective January 18, 2000.
See: 31 N.J.R. 3151(a), 32 N.J.R. 276(a).
Changed N.J.A.C. references throughout.

10:52–13.3 Eligibility and disproportionate share hospital payments for hospitals operating under N.J.S.A. 18A:64G–1

For facilities operating under N.J.S.A. 18A:64G–1 et seq., the disproportionate share allocation may be increased by an amount recommended by the Office of Management and Budget which will consider the total operating cost of the facility less any third party payments, including all other Medicaid payments, as well as payments from non-State sources for services provided by the hospital during the hospital's fiscal year.

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)1 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 a reference to disproportionate share allocations for a reference to disproportionate share adjustments determined by the Essential Health Services.

10:52–13.4 Eligibility for and disproportionate share hospital payments from the Charity Care Component of the Health Care Subsidy Fund

(a) The recommendation from the Department of Health and Senior Services (DHSS) shall be calculated in the following manner pursuant to N.J.S.A 26:2H–18.

1. The determination of the value of the Charity Care Component of the Health Care Subsidy Fund shall be calculated in the following manner:

i. The Department of Health and Senior Services shall use the results of the charity care audit conducted as its definition of charity care incurred by all hospitals.

ii. The New Jersey Department of Health and Senior Services shall report the results of its audit of New Jersey acute care hospital's charity care that was conducted in accordance with N.J.A.C. 10:52–11 to the Division of Medical Assistance and Health Services.

(1) For purposes of determining annual charity care costs, the criteria in N.J.A.C. 10:52–11 shall not apply to a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction pursuant to N.J.S.A. 30:4–1 et seq. A patient so found shall qualify for 100 percent charity care coverage. Hospitals with patients who qualify under this provision shall include the appropriate documentation from the court in the patient's file for audit.

(b) All charity care accounts shall be valued at the Medicaid rate as follows:

1. For inpatient accounts, the New Jersey Department of Health and Senior Services and the New Jersey Department of Human Services shall value each account at the rate Medicaid would have reimbursed hospitals for the services(s).

2. For outpatient accounts, outpatient charity care accounts written-off during the calendar year will be valued as follows: annual outpatient charity care charges multiplied by the ratio of the annual outpatient Medicaid payments to the annual outpatient Medicaid charges associated with paid claims. This Medicaid outpatient payment-to-charge ratio excludes billings for HealthStart and dental services.

3. Disproportionate share adjustments and final rate settlements for the service period shall not be taken into account for the recognition of charity care costs.

(c) For eligible hospitals, charity care subsidy amounts are determined as follows:

1. Eligible hospitals annual charity care subsidy amount is equal to charity care costs as determined by the audit and valued at Medicaid rates.

2. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase used to set Medicaid hospital rates will be used to inflate charity care costs in the current year.

3. In no instances shall payments made during a calendar year exceed the preceding years audited and Medicaid rate valued amounts inflated by TEFRA rates used in the hospital rate setting system.

4. Any overpayments which result from interim payments exceeding the audited payment levels shall be recovered by offsetting all Medicaid payments.

(d) For periods in which the data source excludes Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) in the Medicaid rate, the Medicaid rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified, for periods through State Fiscal Year 1999, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. Effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. These GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid rate adjustments. For the purpose of pricing charity care claims under this section, unless otherwise indicated, the Medicaid rate shall be defined as the Medicaid rate in effect on the date of discharge. The add-ons shall be calculated as follows:

1. The GME add-on shall be calculated as follows:

i. For charity care payments made for January 1998 through June 1998, the charity care GME add-on shall be calculated based on charity care's share of the teaching hospital's aggregate approved GME amount from Worksheet E–3 Part IV as reported on the 1996 submitted Medicare cost report. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, after desk audit. The resulting charity care GME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996, and shall be based on the percentage of charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

ii. For charity care payments made in State Fiscal Year 1999, the charity care GME add-on shall be calculated based on the charity care's share of the teaching hospital's aggregate approved GME amount from Worksheet E–3 Part IV as reported on the most recent submitted Medicare cost report as of October 1 preceding the distribution year. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, after desk audit.

iii. For charity care payments made after State Fiscal Year 1999, the charity care GME add-on shall be calculated based on the charity care share of the teaching hospital's aggregate approved GME amount from Worksheet E–3 Part IV as reported on the most recent submitted Medicare cost report as of February 1 of each year preceding the distribution year. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, after desk audit.

2. The IME add-on shall be calculated as follows:

i. For charity care payments made for January 1998 through June 1998, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the 1996 Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the 1996 Medicare submitted cost report. This charity care IME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996. (Charity care claims are priced at the Medicaid rate in effect when the services are rendered.) This adjustment shall be based on the percentage of inpatient charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

ii. For charity care payments made in State Fiscal Year 1999, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report as of October 1 preceding the distribution year. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

iii. For charity care payments made after State Fiscal Year 1999, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report as of February 1 of each year preceding the distribution year. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

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)2 and 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).
Rewrote the section.

10:52–13.5 Eligibility for and payment of Hospital Relief Subsidy Fund DSH

(a) Hospitals eligible for additional disproportionate share payments may receive an additional payment determined by the Commissioner of the Department of Human Services from the Hospital Relief Subsidy Fund. This additional payment shall be based upon the facility's percentage of clients with HIV, mental health, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse.

1. Payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the

most recent calendar year hospital data available as of October 1 of each year for periods through State Fiscal Year 1999. Effective for periods after State Fiscal Year 1999, payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the most recent calendar year hospital data available as of February 1 of each State fiscal year preceding the distribution year. For the purpose of pricing the problem billed cases listed at (a)1ii(1) below for periods prior to July 6, 1998, the Medicaid rate shall be defined as the rate in effect as of October 1 of each year preceding the distribution year. For the purpose of pricing the problem billed cases listed at (a)1ii(1) below effective on or after July 6, 1998, the Medicaid rate shall be defined as the rate in effect as of February 1 of each State fiscal year preceding the distribution year. Effective for payments on or after July 6, 1998, this payment shall no longer be distributed over a Calendar Year. Instead, it shall be distributed over the State Fiscal Year, July through June.

i. For purposes of determining which hospitals are eligible for payment from the HRSF, a hospital shall satisfy both of the two following independent criteria:

(1) The hospital's cases for the seven categories listed at (a)1ii(1) below, priced at the Medicaid rate, divided by the hospital's Total Operating Revenue, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey Hospitals receiving Medicaid payments. For periods in which the data source excludes GME and IME in the rate, the Medicaid rate shall be adjusted by a hospital-specific GME and IME add-ons. The hospital-specific GME and IME add-ons shall be calculated as defined in (a)1iv below; and

(2) The hospital's charity care days plus the hospital's Medicaid and NJ KidCare–Plan A days, divided by the hospital's total days, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey hospitals receiving Medicaid and NJ KidCare–Plan A payments. For payments distributed in State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid and NJ KidCare–Plan A managed care days if the data is available by May 31, 1998. For payments distributed in State Fiscal Years after State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid and NJ KidCare–Plan A managed care days if the data is available by February 1 prior to the State fiscal year of distribution.

ii. The subsidy shall be an amount allocated by the Commissioner during the fiscal year for this purpose and shall be distributed in the following manner:

(1) The payments for admissions for the following categories are taken from the same calendar year hospital data as defined in (a)4i above maintained by the New Jersey Department of Health and Senior Services (DHSS):

HIV (MDC 24);

Mental Health (MDC 19);

Substance Abuse (MDC 20);

Complex Neonates (DRG 600 through 618, 622, 623, 626, or 627);

Tuberculosis as a major or minor diagnosis (ICD–9 CM; 010.0 through 018.9);

Mothers with substance abuse (MDC 14 with the following codes: ICD–9 CM; 6483, 6555, 304, and 305); and

HIV as a secondary diagnosis (excluding MDC 24; including ICD–9 CM; 0420 through 0422, 0429 through 0433, 0439, 0440, and 0449).

iii. The funding for the subsidy shall be distributed among eligible facilities based upon the hospital's percentage of payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)1iv below, for patient with the categories in (a)1ii(1) above as a percentage of all payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)1iv below, for patients in these categories in eligible hospitals.

iv. For periods in which the data source excludes GME and IME costs in the Medicaid and NJ KidCare–Plan A fee-for-service rate, the rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified in this section, for periods through State Fiscal Year 1999, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. Unless otherwise specified in this section, effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid or NJ KidCare–Plan A rate. The add-ons shall be calculated as follows:

(1) A hospital-specific GME add-on shall be calculated based on the hospital-specific GME per discharge multiplied by the number of cases of the categories defined in (a)1ii(1) above. The hospital-specific GME per discharge shall be calculated on the inpatient share of the aggregate approved GME amount from Worksheet E–3 Part IV of the Medicare submitted cost report divided by the hospital-specific total hospital discharges from Worksheet S–3 Part I of the Medicare submitted cost report.

(2) The hospital-specific IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the number of cases of the categories defined in (a)1ii(1) above, priced at the current available Medicaid inpatient rates. The components of the IME formula, IME intern and resident FTEs, and maintained beds shall be taken from the Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the Medicare submitted cost report used in the calculation.

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)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).
Made internal designation and internal reference changes throughout.

10:52–13.6 Eligibility and payment for DSH funding from the Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients

(a) Disproportionate Share Hospitals which service a large number of low-income mentally ill or developmentally disabled clients may also be eligible to receive increased disproportionate share payment. The amount of payment to be made to facilities which serve a large number of mentally ill low-income clients will be based upon recommendation by the Division of Mental Health Services within the Department of Human Services to the Commissioner of the Department of Human Services. This recommendation will identify hospitals essential to preserve the fragile network of mental health providers in the State. The Division of Developmental Disabilities may also recommend an additional payment to facilities that serve a large number of developmentally disabled clients. These additional payments will assure that these low-income and special needs clients continue to have access to critical care.

1. The Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients shall be an amount allocated by the Commissioner during the fiscal year for this purpose. It shall be distributed in the following manner:

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 Service (CCIS). Payments to a STF 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.

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.

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.

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 guidance to allocate and redistribute disproportionate share hospital (DSH) payments to provide for the patients who were served by the closed hospital. When a hospital closes, the DSH payments that would have gone to that hospital had that hospital not closed shall be reallocated and distributed to eligible hospitals, in accordance with Federal and State laws, rules and regulations. The eligible hospitals that are serving or are expected to serve the patients that would have gone to the closed hospital will receive the closed hospital's allocation. In the event of any future hospital closings, DSH payments to the closed hospital will cease and State laws and/or rules will be enacted or promulgated, respectively, to specify the eligible hospitals and the calculation and distribution of the closed hospital's(s') DSH payment(s).

1. In (b) and (c) below, the reimbursement methodology for DSH applies exclusively to the closure of UHMC.

(b) For the 1998 Charity Care allocation, the Division shall exclude all data pertaining to United Hospitals Medical Center (UHMC).

(c) In calendar year 1998, and each year thereafter, when the source hospital data precedes calendar year 1997, an HRSF allocation that would have gone to UHMC shall be initially calculated. Then the reallocation of UHMC's calculated HRSF allocation shall be calculated and distributed to eligible disproportionate share hospitals using the same data as was used for the original allocation with the exception of market share admission data, which shall be taken from the most recent available UB hospital data in the following manner:

1. DSHs eligible to receive a portion of UHMC's calculated HRSF allocation shall satisfy both of the two following independent criteria:

i. An eligible hospital shall draw its patients from the same neighborhoods, identified by zip codes, that UHMC served. Zip codes are included in the definition of UHMC's market area if they represent areas from which UHMC drew one percent or more of its adult admission or 2.5 percent or more of its pediatric admissions; or if UHMC's admissions represented five percent or more of admissions to all hospitals from that zip code.

ii. An eligible hospital shall have a market share of five percent or more of problem-billed admissions. The market share problem-billed admissions shall be based on the number of admissions from the same neighborhoods, identified by zip code that UHMC served as defined in (c)1i above, for the problem-billed categories as specified in N.J.A.C. 10:52–13.5(a)1ii(1).

2. The available Hospital Relief Subsidy Funds to be reallocated shall be distributed among eligible hospitals based upon an eligible hospital's percentage of market share problem-billed admissions as a percentage of all market share problem-billed admissions of eligible hospitals. The reallocated funds shall be distributed on a monthly basis.

New Rule, R.1998 d.60, effective January 20, 1998.
See: 29 N.J.R. 4376(a), 30 N.J.R. 388(a).
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.

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

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