HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Hospital Services Manual

Readoption with Amendments: N.J.A.C. 10:52

Adopted Repeals: N.J.A.C. 10:52-8.2, 8.3, and 8.4

Proposed: October 2, 2017, at 49 N.J.R. 3294(a).
Adopted: February 6, 2018, by Carole Johnson, Acting Commissioner, Department of Human Services.
Filed: April 16, 2018, as R.2018 d.104, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Agency Control Number: 17-A-04.

Effective Date: April 16, 2018, Readoption;
May 21, 2018, Amendments and Repeals.
Expiration Date: April 16, 2025.

Summary of Public Comment and Agency Response:
No comments were received.

Summary of Agency-Initiated Changes:

The Department of Human Services (Department) and the Division of Medicaid and Health Services (Division) staff believe that the following changes do not require further opportunity for comment, as they are not considered substantial in accordance with N.J.A.C. 1:30-6.3(c)2. The changes update the names of existing offices and do not change the scope or intent of the rule as it was originally proposed.

At N.J.A.C. 10:52-1.14(a)2, the acronym for the Division of Child Protection and Permanency is changed from "DCP&P" to "CP&P," the acronym used by the Division of Child Protection and Permanency for that office.

At N.J.A.C. 10:52-1.14(a)2, the term "district office" is changed to "local office" because that is the term that has been used by the Division of Child Protection and Permanency since 2004. In addition, a grammatical correction is being made, so that the text will read "This telephone contact then shall be confirmed …"

At N.J.A.C. 10:52-2.10(d) and (e), references to the "Division of Child Behavioral Health Services (DCBHS)" are replaced with references to the "Children's System of Care (CSOC)" to reflect the current name of that Division of the Department of Children and Families. Additionally, at subsection (e), there is a grammatical correction being made to delete the word "those," so that the text will now read "Authorization for PH services for individuals under age 18, and individuals at or over the age of 18 and under the age of 21 …"

Federal Standards Statement

42 U.S.C. § 1396d(a) requires a state Title XIX program to provide inpatient and outpatient hospital services to most eligibility groups. Inpatient and outpatient hospital services are considered optional services for the medically needy population; however, New Jersey provides these services automatically to medically needy beneficiaries. Federal regulations at 42 CFR 440.2, 440.10, and 440.20, provide definitions of inpatient hospital services and outpatient hospital services.

Section 1902(a)(13) of the Social Security Act, 42 U.S.C. § 1396a(a)(13), describes the public process a state Medicaid program must use when establishing or amending inpatient hospital rates. Under Federal regulations at 42 CFR 447.272, a state also must assure that the aggregate payments to each group of hospitals do not exceed the amount that reasonably can be estimated would have been paid under Medicare principles of reimbursement. In establishing payment rates for hospital services, a state Medicaid program also must take into account the costs of a hospital that treats a disproportionate share of low-income individuals, consistent with Section 1923 of the Social Security Act, 42 U.S.C. § 1396r-4. This section also describes the minimum amount, as well as the maximum amount, that must be paid for treatment of a disproportionate share number of low-income individuals.

Federal regulations at 42 CFR 447.321 require that the total amounts paid by Medicaid programs, Medicare, and the beneficiary cannot exceed what the total payments would be from Medicare for comparable outpatient services under comparable circumstances.

Title XXI of the Social Security Act allows states to establish a children's health insurance program for targeted children in low-income families. New Jersey elected this option through implementation of the NJ FamilyCare Children's Program. Section 2103, 42 U.S.C. § 1397cc, provides broad coverage guidelines for the program. Section 2110 of the Act, 42 U.S.C. § 1397jj, defines hospital services for the children's health insurance program.

The Department has reviewed the applicable Federal statute and regulations and that review indicates that the rules readopted with amendments and repeals do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 10:52.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

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/NJ FamilyCare fee-for service beneficiaries. These policies and procedures apply to 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/NJ FamilyCare fee-for-service beneficiaries and to Medicaid/NJ FamilyCare fee-for-service services that are not the responsibility of the managed care organization with which the beneficiary is enrolled. Hospital services that 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.

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.

…

"DoAS" means the Division of Aging Services in the New Jersey Department of Human Services.

"DOH" means the State Department of Health.

"Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid/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.

…

"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 paragraphs 1 through 5 above, listed in the definition of "Hospital (Approved Private Psychiatric)" or in addition to paragraphs 1 and 5 above, has facility accreditation by the Joint Commission.

"Hospital (Approved Special)" means an institution that is approved by the New Jersey State Department of Health as a special hospital (for definition of special hospital, see N.J.A.C. 8:43G-1.3(b)2) and which includes any hospital that 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. Is licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;

2. Is accredited by the Joint Commission or the Commission on Accreditation as a hospital or rehabilitation facility; and/or

3.-5. (No change.)

…

"Managed Long-Term Services and Supports (MLTSS)" means services that are provided under the Comprehensive Waiver through Medicaid/NJ FamilyCare managed care organization plans, the purpose of which is to support clients who meet nursing home level of care in the most appropriate setting to meet their specific needs.

…

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health for participation in Title XIX Medicaid and Title XXI Children's Health Insurance Program, which is known in New Jersey as NJ FamilyCare, and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid/NJ FamilyCare beneficiaries, (children and adults) who, due to medical disorders, developmental disabilities, and/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 care and treatment of mental diseases that require continuous 24-hour supervision by qualified mental health professionals or the provision of parenting needs related to growth and development.

…

"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. The institution shall be licensed or formally approved as a hospital by the New Jersey State Department of Health, or certified by the officially designated authority in the state in which the hospital is located; shall meet the requirements for participation in Medicare (Title XVIII) as a hospital; and shall meet the criteria for participation as stated in N.J.A.C. 10:52-1.3.

…

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/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/NJ FamilyCare fee-for-service program as an outpatient hospital service, effective in accordance with the dates in (c) below:

1. (No change.)

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, 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.-8. (No change.)

(c)-(g) (No change.)

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/NJ FamilyCare application:

1.-2. (No change.)

3. A hospital shall submit the form PA-1C to the county welfare agency (CWA) immediately after the birth of a newborn of a mother who is or may become eligible for Medicaid/NJ FamilyCare. (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. (No change.)

ii. With the exception of mothers receiving benefits through the Emergency Services for Aliens Program, a mother who is a Medicaid/NJ FamilyCare beneficiary and her newborn shall have the same Health Benefits Identification (HBID) 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 an HBID Number, and her newborn shall be assigned a separate HBID Number after being determined eligible in accordance with N.J.A.C. 10:69 or 10:72, as applicable.

iii.-iv. (No change.)

4. (No change.)

10:52-1.5 Eligibility of beneficiary for hospital services

(a) Hospital services shall not be reimbursed by the Medicaid/NJ FamilyCare fee-for-service program 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/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare, the beneficiary shall apply for retroactive eligibility, in accordance with N.J.A.C. 10:49-1.1.

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/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.-3. (No change.)

4. Non-physician services, supplies, and equipment supplied by an outside vendor to Medicaid/NJ FamilyCare 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/NJ FamilyCare fiscal agent.

5. (No change.)

(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. (No change.)

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/NJ FamilyCare fee-for-service shall be made, because the services are already included in the DRG reimbursement rate; or

3. (No change.)

(c) Medically necessary inpatient psychiatric services provided in an approved private psychiatric hospital shall be covered by the Division for any Medicaid/NJ FamilyCare beneficiary age 65 or older; or for any other Medicaid/NJ FamilyCare–Children's Program beneficiary before reaching the age of 21, except that a Medicaid/NJ FamilyCare

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)-(j) (No change.)

10:52-1.7 Offset of disproportionate share hospital payments

The Division shall, upon receipt of documentation from the Department of Health, apply an offset to a hospital's disproportionate share hospital Medicaid/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.

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.-2. (No change.)

3. Within one working day of identifying a Medicaid/NJ FamilyCare-Plan A beneficiary as being at risk for nursing facility placement, the hospital notified the Medical Assistance Customer Center (MACC), CWA, 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. (No change.)

(b)-(c) (No change.)

(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 Human Services' Division of Aging Services (DoAS)-designated professional staff during the Preadmission Screening Evaluation and authorization until such time as a NF bed is available to the Medicaid/NJ FamilyCare-Plan A beneficiary. (See N.J.A.C. 10:52-1.11.)

(e)-(g) (No change.)

10:52-1.10 Prior authorization

(a) (No change.)

(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/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 outlined 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/NJ FamilyCare 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 N.J.A.C. 10:49, Appendix, Form 13 or online at: http://www.state.nj.us/humanservices/dmahs/info/resources/macc/index.html.

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

i. For beneficiaries under age 18 and those individuals who are over the age of 18 and under the age of 21 who were receiving mental/behavioral health services through the Department of Children and Families (DCF) and/or the DCF Children's System of Care prior to their 18th birthday, requests for prior authorization of out-of-State psychiatric services shall be coordinated by the Care Management Organization (CMO) or other authorized entity coordinating the beneficiary's mental/behavioral health services and shall be directed by that entity to the DCF Contracted Systems Administrator (CSA). As part of the coordination of inpatient out-of-State psychiatric hospital services for these beneficiaries, the CMO and/or CSA shall direct requests for prior authorization for these services to the DMAHS in accordance with (d)1 above.

2.-4. (No change.)

(e) (No change.)

(f) For Medicaid/NJ FamilyCare 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 care nursing facility (SCNF), or to home care through enrollment into Managed Long-Term Supports and Services (MLTSS) under the New Jersey 1115 Comprehensive Medicaid Waiver (the Comprehensive Waiver), 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 Medicaid/NJ FamilyCare MCO for enrollment into MLTSS. For information on MLTSS, see N.J.A.C. 10:60.

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. (No change.)

2. If the Medicaid/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)-(c) (No change.)

(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/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/NJ FamilyCare eligibility shall be verified by checking the individual's current New Jersey HBID card before rendering any service. (See N.J.A.C. 10:49-2.2 and 2.5, Administration—How to Identify a Medicaid/NJ FamilyCare Beneficiary).

(e) (No change.)

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/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. (No change.)

2. Effective action is defined as telephone notification to the county welfare agency (CWA), or Division of Child Protection and Permanency *[(DCP&P) district]* ***(CP&P) local*** 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 ***then*** 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/NJ FamilyCare-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.

i. (No change.)

10:52-1.15 Utilization control (inpatient services)

(a) (No change.)

(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/NJ FamilyCare services and assesses the quality of those services to Medicaid/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/NJ FamilyCare reimbursement for services rendered to a Medicaid/NJ FamilyCare fee-for-service beneficiary for each period of hospitalization shall be subject to the following requirements:

1. (No change.)

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/NJ FamilyCare program authorizes payment.

ii. (No change.)

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

iv. (No change.)

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

i.-iv. (No change.)

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

vi. (No change.)

3. (No change.)

(d) (No change.)

(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/NJ FamilyCare beneficiary or applicant.

1.-3. (No change.)

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

5.-6. (No change.)

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

1. (No change.)

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

3. (No change.)

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

(a)-(b) (No change.)

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

1.-2. (No change.)

3. "Interdisciplinary team," as described in Federal regulations in 42 CFR 441.156, is comprised of those employed by, or those who provide services to, Medicaid/NJ FamilyCare beneficiaries in the facility or program, and include, at a minimum, either a Board-eligible or Board-certified psychiatrist; or a physician and a clinical psychologist who has a doctoral degree; or a physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a Master's degree in clinical psychology or who has been certified by the State psychological association; and one of the following:

i.-iv. (No change.)

4. (No change.)

(d) (No change.)

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

1. (No change.)

2. Certification for an inpatient applying for Medicaid/NJ FamilyCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (c) above.

3. (No change.)

(f)-(g) (No change.)

SUBCHAPTER 2. POLICIES AND PROCEDURES RELATED TO SPECIFIC SERVICES

10:52-2.2 Blood and blood products

(a) (No change.)

(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/NJ FamilyCare fee-for-service eligible beneficiary is a beneficiary of the blood replacement plan (if available).

2.-3. (No change.)

10:52-2.3 Dental services

(a) Dental services in the outpatient department shall be provided in accordance with the requirements contained in N.J.A.C. 10:56, Dental Services. The outpatient dental department shall be subject to the same policies and procedures that apply to the Medicaid/NJ FamilyCare fee-for-service provider of dental services in the community, with the following exceptions:

1.-2. (No change.)

(b) A hospital with an outpatient dental department serving Medicaid/NJ FamilyCare fee-for-service beneficiaries is given a unique provider number for that department. A hospital that starts an outpatient dental department shall request a provider number for that department from the fiscal agent.

(c) Reimbursement for a dental service is determined by the Commissioner of the Department of Human Services in accordance with N.J.A.C. 10:56, and is based on the same fee, conditions, and definitions for the corresponding service, utilized for the payment of individual Medicaid/NJ FamilyCare fee-for-service dental practitioners and providers in the community, except in cases in which the beneficiary's special healthcare needs, as described in (a)1 or 2 above, require that dental services be performed in the outpatient operating room setting. Reimbursement for outpatient operating room charges for services provided to clients with special healthcare needs, as described in (a)1 or 2 above, shall be at the hospital's outpatient cost-to-charge ratio. In no event shall the charge to the Division exceed the charge by the provider for identical services to other groups or individuals in the community.

1.-2. (No change.)

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

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federally-mandated comprehensive and preventive child health program for Medicaid/NJ FamilyCare-Children's Program fee-for-service beneficiaries from birth through 20 years of age (see 42 CFR 441 Subpart B). The goal of the program is to assess the beneficiary's health needs through initial and periodic examinations (screenings); to provide health education and guidance; and to assure that health problems are prevented, diagnosed, and treated at the earliest possible time.

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

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

1. Screening services, the components of which are described below:

i.-iii. (No change.)

iv. Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines, incorporated herein by reference, as amended and supplemented. The schedule can be found on the Centers for Disease Control (CDC) website at https://www.cdc.gov/ or can be requested from the Centers for Disease Control and Prevention, National Immunization Program, Division of Epidemiology and Surveillance, Mail Stop E61, 1600 Clifton Road, NE Atlanta, Georgia 30333;

v.-viii. (No change.)

2.-5. (No change.)

(c) (No change.)

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, 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) (No change.)

(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 Molina Medicaid Solutions Provider Enrollment, PO Box 4804, Trenton, NJ 08650, or the website www.njmmis.com and click on the Provider Enrollment Application. The application can be completed online or downloaded and mailed or faxed to Molina Medicaid Solutions at (609) 584-1192.

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, 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) (No change.)

(c) The Department of Health administers the Medicaid/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. (No change.)

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 cost filings for payment purposes and shall not be considered an allowable cost under the DRG reimbursement system.

(d) (No change.)

10:52-2.8 Substance use disorder treatment facilities; free-standing

(a) Division requirements for substance use disorder treatment facilities are located in N.J.A.C. 10:66, Independent Clinic Services. Services provided to a Medicaid/NJ FamilyCare fee-for-service beneficiary by a free standing hospital-affiliated substance use disorder treatment facility shall be covered only if those services are eligible for Federal Financial Participation under the Medicaid Program (Title XIX of the Social Security Act) or the NJ FamilyCare program (Title XXI of the Social Security Act) and the following conditions are met:

1. The treatment is prescribed or certified by a physician or an advance practice nurse (APN); and

2. The treatment is provided in a substance use disorder treatment facility licensed or approved by the New Jersey State Department of Health pursuant to N.J.S.A. 26:2G-21 et seq., and N.J.A.C. 10:161A for residential services, N.J.A.C. 10:161B for outpatient services, and/or N.J.A.C. 10:161B-11 for opioid treatment services, as applicable; and

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

(b) Payment for outpatient services provided in a free-standing substance use disorder treatment facility 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/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 use disorder 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 MCO.

(c) Inpatient and outpatient substance use disorder services for Plan D beneficiaries shall be limited to detoxification.

(d) Approved centers shall submit claims only for those procedure codes which correspond to the allowable services included in their New Jersey Medicaid/NJ FamilyCare provider approval letter. Room, board, and other residential services shall not be covered. Claims for reimbursement shall be submitted to the fiscal agent in an accepted format approved by the fiscal agent.

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. Claims for transplant services and organ procurement services rendered to or items dispensed or furnished to an organ donor shall be submitted using the Health Benefits Identification Number of the Medicaid/NJ FamilyCare beneficiary who is receiving the transplant.

2. (No change.)

(b)-(e) (No change.)

(f) For organ transplants for Medicaid/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/NJ FamilyCare fee-for-service program prior to enrollment in a managed care organization under contract with the Department of Human Services.

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/NJ FamilyCare fee-for-service beneficiary. These services shall include:

1.-10. (No change.)

(b)-(c) (No change.)

(d) Authorization for PH services for individuals aged 18 and older who have no involvement with ***the Children's System of Care within*** the Department of Children and Families *[(DCF) and/or the DCF Division of Child Behavioral Health Services]* ***(DCF/CSOC)***, shall be obtained in accordance with N.J.A.C. 10:52A, Adult Acute Partial Hospital and Partial Hospital Services.

(e) Authorization for PH services for individuals under age 18, and *[those]* individuals at or over the age of 18 and under the age of 21 who had been receiving services from the *[Department of Children and Families (DCF) and/or the DCF Division of Child Behavioral Health Services (DCBHS)]* ***(DCF/CSOC)*** prior to their 18th birthday, shall be obtained as follows:

1. *[DCBHS]* ***CSOC*** behavioral healthcare providers may include a referral for PH services in their plans of care. These referrals shall be submitted to the Contracted Systems Administrator (CSA) for approval.

2. (No change.)

3. Authorization for PH services shall not exceed six months without written permission from *[DCBHS]* ***CSOC*** or the CSA.

4. (No change.)

(f)-(i) (No change.)

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

(a) (No change.)

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

…

"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/NJ FamilyCare include: technical occupational skills training, college preparation, student education, including preparation of school assigned classwork or homework and individualized job development.

…

(c)-(g) (No change.)

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. (No change.)

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/NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist. These services include necessary supplies and equipment.

3. (No change.)

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/NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified physical therapist. These services include necessary supplies and equipment.

5.-7. (No change.)

(b)-(d) (No change.)

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 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/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/NJ FamilyCare fee-for-service only when the individual is a Medicaid/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/NJ FamilyCare fee-for-service beneficiary has been denied eligibility for Medicare.

i. (No change.)

(d) (No change.)

10:52-2.13 Sterilization

(a) The Division covers sterilization procedures performed on Medicaid/NJ FamilyCare fee-for-service beneficiaries based on Federal regulations (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)-(f) (No change.)

10:52-2.14 Hysterectomy

(a) The Division covers hysterectomy procedures performed on Medicaid/NJ FamilyCare fee-for-service beneficiaries based on Federal regulations (42 CFR 441.250 through 441.258) and related requirements outlined in this section and in the billing instructions. For hysterectomy requirements see (b) through (d) below. In addition, see N.J.A.C. 10:52-1.13 for the requirements for a Second Surgical Opinion for performing a hysterectomy.

(b)-(c) (No change.)

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

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

i.-ii. (No change.)

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

(1)-(2) (No change.)

(3) Was operated on during a period of the person's retroactive Medicaid/NJ FamilyCare-Plan A eligibility and the individual was informed, before the operation, that the hysterectomy would make her permanently incapable of reproducing or one of the conditions described in (d)1iii(1) or (2) above was applicable. (Include a statement that the individual was informed or describe which condition was applicable). "Retroactive Medicaid eligibility" means the consideration of unpaid medical bills incurred during a three-month period prior to the month the person applied for assistance. (See N.J.A.C. 10:49-2.9, Administration.) Although a physician certification is acceptable for situations described in (d)1iii above, the Division recommends that the FD-189 form be used whenever possible. There is no 30-day waiting period required before a medically necessary hysterectomy may be performed. The standard procedure for a surgical informed consent form within the hospital will suffice.

(e) (No change.)

10:52-2.15 Termination of pregnancy

(a) The Division shall reimburse for medically necessary termination of pregnancy procedures on Medicaid/NJ FamilyCare beneficiaries

when performed by a physician in accordance with N.J.A.C. 13:35-4.2. These services are reimbursed fee-for-service for all beneficiaries, including individuals enrolled in an MCO.

(b)-(e) (No change.)

10:52-2.16 Transportation services; hospital-based

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

1. (No change.)

2. (No change in text.)

3. Each hospital providing ambulance service to Medicaid/NJ FamilyCare fee-for-service beneficiaries shall possess all of the following:

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

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

(b) (No change.)

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

(d) Reimbursement for transportation services to and from hospital-affiliated medical day care centers are included in the medical day care per diem rate and shall not be billed to the New Jersey Medicaid/NJ FamilyCare program by the hospital separately.

(e) Transportation of inpatient beneficiaries transferred to another facility to receive services not available at the sending location, whether the intent is for the beneficiary to return or not, shall be the responsibility of the sending facility. These costs shall be included in the inpatient claim.

SUBCHAPTER 3. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES

10:52-3.1 Purpose

The purpose of HealthStart shall be to provide comprehensive maternity care services to pregnant Medicaid/NJ FamilyCare fee-for-service beneficiaries, (including those determined to be presumptively eligible) and preventive child health care services for Medicaid/NJ FamilyCare fee-for-service beneficiaries up to the age of two.

10:52-3.2 Scope of services

(a) HealthStart maternity care services provided by a HealthStart-certified provider shall be obstetrical care services provided in accordance with the recommendations of the American College of Obstetricians and Gynecologists and a program of support services provided in accordance with the New Jersey Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," dated 1997, available from the Department of Health.

(b)-(c) (No change.)

10:52-3.3 HealthStart provider participation criteria

(a) The following Medicaid/NJ FamilyCare fee-for-service-enrolled provider types shall be eligible to participate as HealthStart providers:

1.-5. (No change.)

6. Certified nurse midwives meeting the New Jersey Department of Health's Improved Pregnancy Outcome criteria.

(b) In addition to New Jersey Medicaid/NJ FamilyCare fee-for-service programs' rules applicable to provider participation, HealthStart providers shall:

1.-2. (No change.)

3. Provide maternity care in accordance with the requirements for issuance of a "HealthStart Certificate," and in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(c) In addition to (a) and (b) above, HealthStart maternity care providers with more than one care site or more than one maternity clinic at the same site that use different staff shall apply for a separate HealthStart Comprehensive Maternity Provider Certificate for each separate clinic. Only those sites which hold a HealthStart Comprehensive Maternity Provider Certificate shall be reimbursed for HealthStart services. Such sites:

1. Shall participate in program evaluation and training activities, including, but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to the New Jersey Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines"; and

2. May determine presumptive eligibility for New Jersey Medicaid/NJ FamilyCare fee-for-service programs, if approved by the Division of Medical Assistance and Health Services.

(d) (No change.)

(e) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Comprehensive Maternity Provider Certificate and to provide services in accordance with the New Jersey State Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines."

(f) A HealthStart Comprehensive Maternity Provider Certificate shall be reviewed by the New Jersey State Department of Health at least every 18 months from the date of issuance.

(g) An application for a HealthStart Comprehensive Maternity Provider Certificate is available from:

HealthStart Program
New Jersey State Department of Health
PO Box 364
Trenton, NJ 08625-0364

(h) (No change.)

10:52-3.4 Termination of HealthStart Comprehensive Maternity Provider Certificate

(a) The New Jersey State Department of Health shall enforce its requirements for HealthStart Comprehensive Maternity Provider Certificates and for evaluation and enforcement of its requirements within the standards and guidelines for HealthStart providers.

(b) Failure to comply with HealthStart standards shall be cause for termination of the HealthStart Comprehensive Maternity Provider Certificate by the New Jersey State Department of Health.

1. A HealthStart Comprehensive Maternity Provider Certificate shall be time-limited. Failure to complete the recertification process shall result in termination of the provider's HealthStart provider status by the New Jersey State Department of Health.

2. (No change.)

10:52-3.8 Maternity medical care services

(a) Maternity medical care services shall include antepartum, intrapartum, and postpartum care provided by the obstetrical care practitioner(s) in accordance with New Jersey State Department of Health's HealthStart Comprehensive Maternity Care Services Program Guidelines.

(b)-(e) (No change.)

10:52-3.9 Health support services

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

1.-3. (No change.)

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

1.-6. (No change.)

(c) (No change.)

(d) Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with the Department of Health's "HealthStart

Comprehensive Maternity Care Services Program Guidelines." Services shall be provided as follows:

1.-4. (No change.)

(e) One face-to-face preventive health care contact shall be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit in accordance with the Department of Health's "HealthStart Comprehensive Maternity Care Services Program Guidelines," as follows:

1. (No change.)

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

(f) (No change.)

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

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

(a) (No change.)

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

(c)-(k) (No change.)

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

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

(b)-(d) (No change.)

10:52-3.12 Standards for HealthStart pediatric care

(a) (No change.)

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

1.-3. (No change.)

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

(a)-(c) (No change.)

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

SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

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

(a)-(c) (No change.)

(d) The Medicaid/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)-(f) (No change.)

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) (No change.)

(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 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. (No change.)

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 FamilyCare fee schedule for the profile itself.

(2) (No change.)

2.-9. (No change.)

(c) Emergency room visits for treatment of conditions that are not the responsibility of an MCO or for Medicaid/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.-2. (No change.)

3. Hospitals shall not refuse to provide emergency room services to any Medicaid/NJ FamilyCare 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 MCO 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.

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, which meet both conditions in (a)1 below will be eligible for increased payments for capital project funding related to its Medicaid/NJ FamilyCare-Plan A managed care utilization.

1.-2. (No change.)

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

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

(a) The Division shall reimburse an out-of-State approved acute care general hospital (see N.J.A.C. 10:52-1.2, Definitions) for providing

inpatient and outpatient hospital services to New Jersey Medicaid/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) and (c) below, and for outpatient services is outlined in (d) and (e) below. See (f) below for the procedure for rate appeals for out-of-State acute care general hospitals.

(b) Reimbursement for inpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid/NJ FamilyCare program and participating in the Medicaid program in the state in which the hospital is located, shall be based on the following criteria:

1.-2. (No change.)

(c) In the event an out-of-State acute care general 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:

1. (No change.)

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

3. (No change.)

(d) Reimbursement for outpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid/NJ FamilyCare program and participating in the Medicaid program in the state in which the hospital is located shall be based on the following criteria:

1.-2. (No change.)

(e)-(f) (No change.)

10:52-4.7 Medicare/Medicaid or Medicare/NJ FamilyCare claims

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

(b) (No change.)

(c) When Medicaid/NJ FamilyCare is not the primary payer on an inpatient hospital claim, payment by Medicaid/NJ FamilyCare will be made at the lesser of:

1. The Medicaid/NJ FamilyCare allowed amount minus any other payment(s); or

2. (No change.)

(d)-(e) (No change.)

10:52-4.8 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

(a)-(c) (No change.)

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

1.-3. (No change.)

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

i.-iii. (No change.)

iv. Inpatient substance use disorder detoxification services; or

v. (No change.)

(e)-(f) (No change.)

10:52-4.9 Settlement for Medicaid/NJ FamilyCare fee-for-service services

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

1.-2. (No change.)

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

4.-5. (No change.)

SUBCHAPTER 5. PROCEDURAL AND METHODOLOGICAL REGULATIONS

10:52-5.4 Development of standards

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

10:52-5.6 Financial elements reporting/audit adjustments

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

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

2.-3. (No change.)

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

10:52-5.8 Patient care cost findings: direct costs per case, physician and nonphysician

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

1. (No change.)

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

3.-4. (No change.)

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

1. For each patient with a Uniform Bill (UB), measures of resource use shall be calculated to distribute costs among the UB. Measures of resource use represent services provided to patients associated with each cost center. Patient days are associated with routine service cost, emergency room admissions with emergency service cost, and ancillary

and therapeutic charges with ancillary and therapeutic service cost. The measures of resource use is a ratio of admissions reported on the hospital's cost report over the hospital's UB billing data. Costs are derived from the Actual Reporting Forms and are associated with admissions. Therefore, an adjustment is made to align the measures of resource use to the inpatient cost. The adjustment is the ratio of total admissions to total UB records. This results in a total adjusted measure of resource use. The hospitals shall make reasonable efforts to correct data unacceptable to the Division or Department of Health.

(No change in table.)

(c) (No change.)

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. (No change in text.)

(b) Determination of the labor equalization factor to calculate Statewide standard costs per case shall be as follows:

1. (No change.)

2. The Labor Market Areas recognized in 1990 by the Department of Health will be used for rate setting in subsequent years.

3.-8. (No change.)

(c) Calculation of standards shall be as follows:

1. Effective for services provided on or after October 1, 1996, the calculation of standards shall be based on all hospital UB records for Medicaid/NJ FamilyCare patients, where Medicaid/NJ FamilyCare is the primary payor. The cost per case of each hospital's Medicaid/NJ FamilyCare 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.

2. (No change in text.)

(d) (No change in text.)

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:

i. (No change in text.)

(b) (No change.)

10:52-5.14 Capital facilities

(a) (No change.)

(b) Any new capital facilities construction with a valid certificate of need from the New Jersey Department of Health may request a capital facilities adjustment in rates through the review and appeal process as described in N.J.A.C. 10:52-9, except that a hospital which meets the requirements of (b)1 below may request a capital facilities adjustment in accordance with (b)2 below.

1. A hospital may submit an appeal specific to its CFA without going through the full rate review process, if:

i.-ii. (No change.)

iii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low-income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low-income revenue percentage shall be based on the sum of the Medicaid/NJ FamilyCare 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. (No change.)

3. In addition to an adjustment to its rates, a hospital that meets the condition of (b)1 above shall receive an additional payment for its Capital Project Funding related to its Medicaid/NJ FamilyCare-Plan A managed care utilization.

i. (No change.)

ii. The hospital-specific Capital Project Funding annual amount shall be equal to the principal and interest cost associated with the capital project, multiplied by the Medicaid/NJ FamilyCare-Plan A managed care percent for inpatient services, less any capital costs included in the managed care rates.

SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

10:52-6.1 Reporting principles

The reporting principles and concepts adopted by the Department of Health at N.J.A.C. 8:31B-4.1 through 4.25 shall be used for Medicaid/NJ FamilyCare fee-for-service rates.

10:52-6.17 Educational, research, and training programs

(a) (No change.)

(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. 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) (No change.)

10:52-6.34 Obstetric Acute Care Unit (OBS)

(a) The functions included in the Obstetric Acute Care Unit (OBS) cost center are as follows:

1. The provision of care to the mother before, during, and following delivery on the basis of physicians' orders and approved nursing care plans shall be provided in the Obstetric Acute Care Unit. Obstetrics may include services to clean gynecological patients treated in beds licensed by the Department of Health as obstetrics.

2.-3. (No change.)

(b) (No change.)

10:52-6.41 Newborn Nursery (NBN)

(a) The functions included in the Newborn Nursery (NBN) cost center are as follows:

1.-2. (No change.)

3. Costs associated with units designated by the Department of Health as perinatal centers pursuant to N.J.A.C. 8:33C shall be reported in this cost center.

(b) (No change.)

10:52-6.66 Medical Records (MRD)

(a) The functions included in the Medical Records (MRD) cost center are as follows:

1. Medical Records shall be responsible for creating and maintaining a medical record for all patients and for maintaining a tumor registry in accordance with Department of Health requirements. (N.J.A.C. 8:43G-21.2(a)). The revenue and costs associated with medical records transcriptions for persons outside of the hospital shall be reported as reconciling items.

2. (No change.)

(b) (No change.)

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 in approved research. Approved research shall be reported pursuant to N.J.A.C. 10:52-6.25, 6.26, and 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.

SUBCHAPTER 7. DIAGNOSIS RELATED GROUPS (DRG)

10:52-7.1 Diagnosis Related Groups (DRG)

(a) (No change.)

(b) The appropriate classifications are reported here and these are the only classifications allowable for DRG assignment.

1. Principal diagnosis: The condition established after study shall be chiefly responsible for occasioning the admission of a patient to the hospital for care. The principal diagnosis must be coded using the International Classification of Diseases, 10th Revision, with Clinical Modifications (ICD-10-CM).

2. Secondary diagnosis: Conditions that exist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay. Diagnoses which have no bearing on the treatment received during a current hospital stay are not appropriate for use in DRG assignment. All secondary diagnoses must be coded using ICD-10-CM.

3. Principal and other procedures: Diagnostic and therapeutic procedures performed during a patient stay. All procedures must be coded using ICD-10-CM.

4.-8. (No change.)

(c) (No change.)

10:52-7.3 List of Diagnosis Related Groups

(a) (No change.)

(b) The following are abbreviations used in ICD-10-CM DRG English descriptors.

1.-11. (No change.)

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) Medicare principles of reimbursement for GME and IME are as follows:

1. (No change.)

2. IME is calculated based on Medicare's IME formula, at 42 CFR 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/NJ FamilyCare-Plan A fee-for-service inpatient DRG payments (net of GME and IME) to arrive at the Medicaid/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.

10:52-8.2 through 8.4 (Reserved)

10:52-8.5 Hospital fee-for-service reimbursement for Graduate Medical Education (GME) effective on or after July 6, 1998

(a) (No change.)

(b) The source of the data used to allocate the GME payment is the Medicare/Medicaid submitted cost report that is on file with DMAHS as of October 31 of the current calendar year for GME payments for the State fiscal year commencing July 1 of the subsequent year with corresponding 24-month fee-for-service Medicaid/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/Medicaid/NJ FamilyCare submitted cost report. The hospital-specific Medicaid/NJ FamilyCare-Plan A fee-for-service days shall come from the 24-month data fee-for-service Medicaid/NJ FamilyCare-Plan A inpatient paid claims data.

1. For hospitals with psychiatric units included in the Medicare Inpatient Prospective Reimbursement System for Medicare reporting purposes but excluded for Medicaid/NJ FamilyCare reporting purposes, the data from the hospital-submitted worksheets for the Medicaid-excluded psychiatric units shall be used.

(c) (No change.)

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

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

SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

10:52-9.1 Review and appeal of rates

(a) (No change.)

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

1. (No change.)

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

i.-vii. (No change.)

viii. Any analyses of the hospital's marginal cost in providing services to Medicaid/NJ FamilyCare-Plan A fee-for-service or other categories of patients;

ix. Cost accounting documentation or reports pertaining to the hospital's cost incurred in treating Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries or the comparative cost of treating Medicaid/NJ FamilyCare-Plan A fee-for-service and other patients;

x.-xi. (No change.)

xii. Evidence that the appealed rates jeopardize the long term financial viability of the hospital (that is, that the hospital is sustaining a marginal loss in treating Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries) and that the hospital is necessary to provide access to care for Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries.

(c)-(d) (No change.)

SUBCHAPTER 10. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

10:52-10.1 Introduction

(a)-(b) (No change.)

(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:

Column Title	Description
IND	(Indicator Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid/NJ FamilyCare fee-for-service program's qualifications and requirements when a procedure or service code is used. Explanation of indicators and qualifiers used in this column are identified below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. "F" preceding any procedure code indicates that this code, when used primarily for the diagnosis and treatment of infertility, is not covered by the New Jersey Medicaid/NJ FamilyCare program. "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:52-10.3. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:52-10.4.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance has been identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid/NJ FamilyCare program's recognized modifier codes are listed at N.J.A.C. 10:52-10.5.
DESCRIPTION	Lists the code narrative. (Narratives for Level I codes are found in the CPT. Narratives for Level II codes are found at N.J.A.C. 10:52-10.3.)
MAXIMUM FEE ALLOWANCE	Lists the New Jersey Medicaid/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.

1.-2. (No change.)

(d) (No change.)

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

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

1. (No change.)

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/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.-8. (No change.)

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/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. (No change.)

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/NJ FamilyCare fee-for-service programs' recognized modifier codes are:

Modifier Code	Description
(No change.)	(No change.)

SUBCHAPTER 11. CHARITY CARE

10:52-11.1 Charity care audit functions

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

(b) The Department of Health shall 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).

10:52-11.2 Sampling methodology

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

10:52-11.3 Charity care write-off amount

(a) The Department of Health shall value charity care claims at the Medicaid/NJ FamilyCare rate. The Medicaid/NJ FamilyCare rate, for purposes of valuing a given charity care claim, shall be based on the New Jersey Medicaid/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare rate shall be recorded as a contractual allowance.

(c) (No change.)

(d) The Department of Health will calculate the cost of charity care services at the rate that would have been paid by the New Jersey Medicaid/NJ FamilyCare program.

10:52-11.5 Charity care screening and documentation requirements

(a) The hospital shall provide all patients with an individual written notice of the availability of charity care and Medicaid/NJ FamilyCare, in a form provided by the Department of Health, at the time of service, but no later than the issuance of the first billing statement to the patient.

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this subchapter. The applicant's financial file for audit shall contain the completed charity care application in a format approved by the Department of Health, as well as the supporting documentation which led to the determination of eligibility. For purposes of the audit, the hospital shall include in or with the file all other information necessary to demonstrate compliance with any of the audit steps.

(c) (No change.)

(d) If the applicant is uninsured, or the applicant's health insurance is unlikely to pay the bill in full (based on hospital staff's previous experience with the insurer), and the applicant has not paid at the time of service any amounts likely to be remaining, the hospital shall make an initial determination for eligibility for any medical assistance programs available. The hospital shall refer the applicant to the appropriate medical assistance program and shall advise the medical assistance office of the applicant's possible eligibility. The applicant's financial file for audit shall indicate either that the applicant declined to be screened for medical assistance; that the applicant was screened but was determined ineligible; or that the applicant was screened and referred to the medical assistance program for possible eligibility. If the hospital does not screen the applicant for medical assistance, the record shall indicate the reason(s) why the applicant was not screened and the efforts the hospital made to obtain the screening. If an applicant affirmatively declines to be screened or is referred to a medical assistance program and does not return with an appropriate determination, the hospital will use the following procedures:

1. If the applicant affirmatively declines to be screened, or does not complete the medical assistance application process within three months after the date of service, or files an application after the application deadline, but is otherwise documented as eligible for charity care, the hospital:

i. (No change.)

ii. Shall report the Medicaid/NJ FamilyCare value amount as charity care; and

iii. (No change.)

2.-3. (No change.)

(e)-(l) (No change.)

10:52-11.8 Income eligibility criteria and documentation

(a) (No change.)

(b) The provisions of 42 U.S.C. § 9902(2), the poverty guidelines revised annually by the United States Department of Health and Human Services (HHS), are hereby incorporated by reference. (For further information on the poverty guidelines, contact the Office of the Assistant Secretary for Planning and Evaluation, Room 415F, Department of Health and Human Services, 200 Independence Avenue, SW Washington, D.C. 20201, Telephone (202) 690-7858; Website: https://aspe.hhs.gov/.) A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

1.-2. (No change.)

(c)-(e) (No change.)

10:52-11.9 Proof of income

(a)-(b) (No change.)

(c) If a minor applicant's parents are divorced, and one of the parents is uncooperative, as defined in (c)1 through 3 below, with the application process, the requirement for that parent's income may be waived by the hospital, after the case is reviewed by the Department of Health based on the following:

1.-3. (No change.)

(d) If an applicant is separated, but not legally divorced, from his or her spouse, the applicant may document that he or she has no financial ties with the estranged spouse in accordance with (d)1 through 4 below, and the hospital may waive the requirement for the estranged spouse's income, after the case is reviewed by the Department of Health, if documentation has been provided in accordance with the following:

1.-4. (No change.)

(e)-(g) (No change.)

10:52-11.13 Application and determination

(a) Consistent with the requirements of N.J.A.C. 10:52-11.6, 11.7, 11.8, 11.9, 11.10, 11.11, and 11.12, the Department of Health shall specify the elements to be included in charity care application and eligibility determination forms used by all disproportionate share hospitals for the Charity Care Program; hospitals shall not omit or add to these elements. The application form shall advise patients of the penalties for providing false information on a charity care application. The list of required elements may be obtained from the Department of Health, Division of Health Services Oversight, Hospital Financial Reporting and Support.

(b)-(c) (No change.)

(d) The hospital shall provide each applicant who requests charity care and is denied it, in whole or part, with a written and dated statement of the reasons for the denial, including information required in (c) above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. Where a denial is based on a presumption that the applicant is eligible for, but not enrolled in Medicaid/NJ FamilyCare, the information upon which the denial is based must be documented.

10:52-11.15 Adjustment methodology

(a) (No change.)

(b) The charity care write-off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid/NJ FamilyCare program. To the extent that a hospital's total charity care write-off amount is overstated, the amount will be reduced by the amount of the overstatement.

(c) In addition to adjustments required to ensure that the charity care write-off amount is equal to the Medicaid/NJ FamilyCare reimbursement rates, the write-off amount may also be revised on the basis of listing, alternative documentation and/or compliance adjustments, in that order.

(d) (No change.)

(e) In accordance with the provisions of N.J.A.C. 10:52-11.11, use of alternative documentation in any one of the steps to determine an applicant's eligibility for charity care shall cause that applicant's file to be designated as an alternative documentation file. A ratio shall be developed using sample dollars with alternative documentation as a percentage of total sample dollars. If this ratio is less than or equal to.10, there shall be no adjustment. If this ratio is greater than.10, the ratio shall be reduced by.10 and then multiplied by the hospital's charity care write-off amount at the Medicaid/NJ FamilyCare rate for the calendar year being audited. This amount shall be subtracted from the hospital's charity care write-off amount for the calendar year being audited at the Medicaid rate after listing adjustment.

(f) In accordance with the provisions of N.J.A.C. 10:52-11.5 through 11.11, noncompliance with any one of the steps to determine an applicant's eligibility for charity care shall cause that applicant's file to be designated as a failed compliance file. A ratio shall be developed using sample dollars from failed compliance files as a percentage of total sample dollars. If this ratio is less than.10, there shall be no adjustment. If this ratio is equal to or greater than.10, the ratio shall be multiplied by the hospital's charity care write-off amount for the calendar year being audited at the Medicaid/NJ FamilyCare rate. This amount shall be subtracted from the hospital's charity care write-off amount at the Medicaid rate after alternative documentation adjustment.

(g) (No change.)

(h) The Department of Health's auditor will provide the hospital with a copy of its audit findings and recommended adjustments. Eligible hospitals shall sign the auditor's audit findings, indicating their agreement or disagreement with the audited charity care write-off amount. If the hospital disagrees with the audit findings, the hospital shall submit a request for a departmental review within 15 days of receiving the auditor's report and shall, within the request, detail the reasons for disagreement with the auditor's findings. The Department will review the auditor's findings, as well as the hospital's objections, and will advise the hospital within 30 days of receipt of the request for review of the total dollar value of the hospital's charity care write-off for the period audited, priced at the Medicaid/NJ FamilyCare rate.

(i) (No change.)

10:52-11.16 Charity care applications of patients admitted through emergency room

(a)-(c) (No change.)

(d) If the applicant's medical condition permits, the hospital shall also, prior to the applicant's discharge, request the following information, which shall be recorded by the hospital on a form approved by the Department of Health:

1.-7. (No change.)

(e)-(j) (No change.)

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

10:52-12.1 Definitions

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

…

"Clean charity care claim" means a charity care claim that is received by the Fiscal Agent and accepted by the Fiscal Agent in accordance with electronic media procedures and is adjudicated and priced no later than two years after the date of patient discharge (inpatient) or date of service (outpatient). Claims that are denied are not clean claims. A clean charity care claim includes:

1. The name and provider number assigned by the Department of Health to each licensed hospital;

2.-6. (No change.)

…

10:52-12.2 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund

(a) This subchapter sets forth the requirements of the New Jersey State Department of Health that the provider shall adhere to when submitting a charity care claim.

(b) (No change.)

(c) The State of New Jersey uses a Fiscal Agent for the pricing of charity care claims.

1. The Department of Health will advise hospitals in December of each year of the Fiscal Agent's pricing cycle and submission cut-off dates for the following calendar year. Charity care claims shall be adjudicated monthly by the Fiscal Agent.

2.-9. (No change.)

(d)-(e) (No change.)

10:52-12.3 Basis of pricing for charity care claims

(a) All hospital outpatient and inpatient charity care claims shall be priced based on the New Jersey Medicaid/NJ FamilyCare program's pricing and program policies for hospital outpatient and inpatient hospital services. (See this chapter, and, specifically, N.J.A.C. 10:52-1.6, Covered services (inpatient and outpatient services), and 10:52-4, Basis of Payment.)

1. Exception: Although the New Jersey Medicaid/NJ FamilyCare program reimburses dental services on a fee-for-service schedule for outpatient hospital charity care claims, dental services shall be priced based on hospital outpatient cost to charge ratio as described in N.J.A.C. 10:52-4.3. All other hospital outpatient services for charity care shall also be priced according to the Medicaid/NJ FamilyCare hospital outpatient methodology. (See N.J.A.C. 10:52-4.3.)

(b) (No change.)

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/NJ FamilyCare inpatient hospital utilization rate that is one standard deviation above the mean Medicaid/NJ FamilyCare utilization rate for hospitals receiving Medicaid/NJ FamilyCare 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)-(c) (No change.)

(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/NJ FamilyCare utilization rate (as defined in N.J.A.C. 10:52-13.5).

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 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.

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/NJ FamilyCare payments, as well as payments from non-State sources for services provided by the hospital during the hospital's fiscal year.

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

(a) The recommendation from the Department of Health 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 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 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) (No change.)

(b) All charity care accounts shall be valued in accordance with the Medicaid methodology as follows:

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

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

3. (No change.)

(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/NJ FamilyCare rates.

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

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

(d) For periods in which the data source excludes Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) in the Medicaid/NJ FamilyCare rate, the Medicaid/NJ FamilyCare rate shall be adjusted by hospital-specific GME and IME add-ons. 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/NJ FamilyCare rate adjustments. For the purpose of pricing charity care claims under this section, unless otherwise indicated, the Medicaid/NJ FamilyCare rate shall be defined as the Medicaid/NJ FamilyCare 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. (No change in text.)

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

i. (No change in text.)

(e) As provided in N.J.S.A. 26:2H-18.59e, the charity care subsidy shall be determined according to the following methodology:

1. The hospital-specific "documented charity care" shall be calculated from the dollar amount of charity care provided by the hospital that is submitted to the charity care fiscal intermediary and valued at the same rate paid to that hospital by the Medicaid/NJ FamilyCare program. A sample of the claims submitted by the hospital to the fiscal intermediary shall be subject to an audit conducted pursuant to charity care eligibility criteria. For each fiscal year, documented charity care claims shall be equal to the Medicaid/NJ FamilyCare-priced amounts of charity care claims submitted to the fiscal intermediary for the most recent calendar year, adjusted as necessary to reflect the audit results, as well as GME/IME, in accordance with (d) above.

2.-4. (No change.)

5. The hospital-specific "revenue from private payers" shall be equal to the sum of the gross revenues reported to the Department in the hospital's most recently available New Jersey Hospital Cost Report (see N.J.A.C. 8:31B-3.16) for all non-governmental, or private third party payers, including, but not limited to, Blue Cross and Blue Shield plans, commercial insurers and the non-governmental, or private accounts of managed care organizations. Gross revenue derived from governmental accounts of managed care organizations from the Medicare, Medicaid, NJ FamilyCare (including NJ FamilyCare–Children's Program) programs, will not be included in the category of "revenue from private payers."

6.-7. (No change.)

8. The hospital-specific "income from operations" shall be defined by the Department of Health (DOH) in accordance with financial reporting requirements established pursuant to N.J.A.C. 8:31B-3.3.

9. The hospital-specific "total operating revenue" shall be defined by the DOH in accordance with financial reporting requirements established pursuant to N.J.A.C. 8:31B-3.3.

10.-12. (No change.)

(f) The charity care subsidy payment schedule for the fiscal year shall be implemented the first month after the Department distributes the schedule to all disproportionate share hospitals. The charity care subsidy payment schedule constitutes advice to the hospitals of the allocation of charity care subsidies available for that fiscal year. Hospitals shall receive the charity care subsidy payments in 12 monthly installments.

1. A hospital which suspects that the charity care subsidy payment schedule reflects a calculation error shall notify the Commissioner of DOH in writing of the suspected calculation error within 15 days of issuance of the schedule. Failure by the charity care subsidy payment schedule to reflect specific charity care claims or hospital cost report data, including corrections, shall not constitute a calculation error. If, upon review, the Commissioner determines that a calculation error did occur, a revised charity care subsidy payment schedule shall be issued.

2. (No change.)

3. The Commissioner of the Department of Health shall schedule a detailed review to be conducted by the Department with the hospital not more than 45 calendar days following receipt of the appeal document. If the hospital fails to appear on the established date, it shall have forfeited its right of appeal and the charity care subsidy payment schedule shall be deemed to have been accepted by the hospital.

4.-5. (No change.)

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. 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 effective on or after July 6, 1998, the Medicaid/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare-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/NJ FamilyCare-Plan A payments. For payments distributed in State Fiscal Years after State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid FamilyCare-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:

(A) HIV (MDC 24);

(B) Mental Health (MDC 19);

(C) Substance Abuse (MDC 20);

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

(E) Tuberculosis as a major or minor diagnosis (ICD-10-CM; 010.0 through 018.9);

(F) Mothers with substance abuse (MDC 14 with the following codes: (ICD-10-CM; 6483, 6555, 304, and 305); and

(G) HIV as a secondary diagnosis (excluding MDC 24; including ICD-10-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/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare-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, 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/NJ FamilyCare-Plan A rate. The add-ons shall be calculated as follows:

(1) (No change.)

(2) The hospital-specific IME add-on shall be calculated based on Medicare's IME formula, at 42 CFR 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/NJ FamilyCare 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.

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 payments. 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 and Addiction Services (DMHAS) 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 and Addiction 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 DMHAS.

ii. Hospitals who are not a STCF or CCIS, but which are under contract with the Division of Mental Health and Addiction 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 DMHAS.

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

(a) (No change.)

(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. (No change.)

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, as follows:

i.-ii. (No change.)

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 DOH, but the closed hospital's UB data will not be included in making this determination.

(c)-(e) (No change.)

(f) Notwithstanding any other provision of this rule, if the Commissioner of Health 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.-2. (No change.)

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

10:52-14.3 Calculation of the DRG weights

(a) A Statewide relative weight for each DRG was developed using the most recent available audited Medicare cost report data and Medicaid/NJ FamilyCare paid claims data for the same year. The cost data used excludes direct and indirect medical education costs. In the initial rate year, 2003 audited Medicare cost report data and 2003 Medicaid/NJ FamilyCare claim data were used to develop the DRG weights.

(b) Charges from the Medicaid/NJ FamilyCare claims were converted to cost by multiplying the routine cost center per diem costs from the Medicare cost reports times the number of routine days from the Medicaid/NJ FamilyCare claims using a hospital specific crosswalk between revenue codes and hospital cost centers, and multiplying the ancillary cost center cost-to-charge ratios from the Medicare cost reports times the ancillary charges from the Medicaid/NJ FamilyCare claims using a hospital specific crosswalk between revenue codes and hospital cost centers.

(c)-(d) (No change.)

(e) DRGs that did not have sufficient Medicaid/NJ FamilyCare claim volume to develop a statistically valid weight using the DRG weight setting methodology in (d) above had a weight derived from additional sources. For these DRGs, charity care claim volume was added to the Medicaid/NJ FamilyCare claim volume using the methodology in (d) above to establish a stable DRG weight. In cases where using this secondary data set did not yield a stable DRG weight, the normalized DRG weight from the corresponding New York AP DRG Grouper was used.

(f)-(i) (No change.)

10:52-14.6 Determination of the Statewide base rate

(a) The Division established an initial Statewide base rate, which applies to all hospitals. Those hospitals meeting the criteria for add-on amounts in accordance with N.J.A.C. 10:52-14.7 have rates higher than the Statewide base rate. The initial Statewide base rate is established as follows:

1. (No change.)

2. The amount calculated in (a) above is reduced to account for the following DRG system payments: add-on amounts under N.J.A.C. 10:52-14.7, outlier payments, payments for alternate levels of care and the effect on payments where Medicaid/NJ FamilyCare is not the primary payer (that is, Medicare claims partially paid by Medicaid/NJ FamilyCare and third party liability claims). A reduction in payments was also made to remove an amount for utilization review services that were previously paid for by hospitals, which will become a State obligation, effective August 3, 2009.

i. If the Division does not have a contractor for hospital utilization review services by August 3, 2009, hospitals will receive separate payments equal to the aggregate amount of utilization review removed before establishing the Statewide base rate. Each hospital will receive a utilization review payment based on its proportional amount of Medicaid/NJ FamilyCare fee-for-service discharges from the most recent available 24 months of Medicaid/NJ FamilyCare paid claims data. The allocation of utilization review payments will account for closed hospitals in accordance with the method set forth in N.J.A.C. 10:52-14.7(d).

(b) The Statewide base rate is increased by the hospital specific add-on amounts to determine a final rate for each hospital. The final rate for new hospitals and hospitals that had no Medicaid/NJ FamilyCare discharges in the base year are set at the Statewide base rate.

(c)-(e) (No change.)

10:52-14.7 Criteria to qualify for add-on amounts to the Statewide base rate

(a) Each rate year, the Division will determine if each general acute hospital participating in the New Jersey Medicaid/NJ FamilyCare program is eligible for add-on amounts. The Division determined hospital eligibility for add-on amounts in the initial rate year as described in (c) below and eligibility and add-ons will be calculated each rate year thereafter using the most recent year for which there is 24 months of Medicaid/NJ FamilyCare paid claims data. However, if the initial rate year is a partial year, add-on amounts will remain the same for the second rate-year.

(b) (No change.)

(c) Add-on amounts were developed to provide additional payments for high volumes of inpatient services to Medicaid/NJ FamilyCare and other low income patients. These add-on amounts increase the Statewide base rate for qualifying hospitals as a percentage add-on to the Statewide base rate. These add-on amounts are based on high volume Medicaid/NJ FamilyCare inpatient services or low income access.

1. High volume Medicaid/NJ FamilyCare inpatient services, referred to as critical services, are comprised of two categories; the first category is maternity and neonates, and the second category is mental health and substance abuse. The data used to determine eligibility as a critical service provider is patient days from the Medicaid/NJ FamilyCare fee-for-service claims for all DRGs in Major Diagnostic Categories (MDCs) 14, 15, 19, and 20, as specified in the All Patient Diagnosis Related Groups Patient Classification System Definitions Manual published by 3M Health Information Systems. The methodology determines eligibility for add-on amounts separately for each of the two categories, ranks patient day volume from high to low, and deems eligible those hospitals with patient days in the top 25 percent (referred to as the first quartile) of the total number of hospitals. Hospitals ranked in the first quartile for either category qualify for a 10 percent add-on to the Statewide base rate, and those hospitals that ranked in the first quartile of both categories qualify for a 15 percent add-on to the Statewide base rate.

2. High volume low income utilization, referred to as critical access, is expressed as a percentage and is defined as the sum of Medicaid/NJ FamilyCare fee-for-service days, Medicaid/NJ FamilyCare managed care days and charity care days, divided by total patient days. The data sources are Medicaid/NJ FamilyCare fee-for-service and charity care claims adjudicated by the New Jersey Medicaid/NJ FamilyCare fiscal agent and Medicaid/NJ FamilyCare MCO and total patient days as reported on the Medicare cost reports. Each hospital's low income utilization percentage is ranked from high to low, and hospitals in the first quartile are classified as critical access hospitals. Critical access hospitals qualify for a 10 percent add-on to the Statewide base rate. However, those hospitals with the highest low income utilization percentages for the top 10 percent of the total number of hospitals qualify for an additional five percent, which equals a 15 percent add-on to the Statewide base rate.

3. The Medicaid/NJ FamilyCare claims data used to calculate the add-on amounts as defined in (c)1 and 2 above, will be the most recent year of data available for which the Division has 24 months of Medicaid/NJ FamilyCare paid claims data as of July 1 of the year prior to the rate year. For each year the add-on amounts are calculated, the Medicaid/NJ FamilyCare claims will have DRGs assigned using the version of the AP-DRGs Grouper that was used to pay the claims in that year.

4. (No change.)

(d) Regarding the treatment of closed hospitals, the calculation of add-on amounts will be determined as follows:

1. Hospitals expected to be closed by December 31 of the year prior to the rate year will be excluded from the add-on calculations. Only those hospitals with a Certificate of Need for closure approved by the Department of Health (DOH) and a closure date set by DOH of December 31 or earlier will be excluded from the add-on calculations. The Division will only use hospital closure information available up to October 1 of the year prior to the rate year for add-on calculations; and

2. (No change.)

10:52-14.8 DRG daily rates

(a) The Division will calculate DRG daily rates for each DRG for each hospital. These rates are used for calculating reimbursement in cases involving transfers, same-day discharges, and for cases in which Medicaid/NJ FamilyCare eligibility began or ended during the inpatient stay.

(b) (No change.)

10:52-14.9 Hospital specific Medicaid/NJ FamilyCare cost-to-charge ratios

(a)-(c) (No change.)

(d) The Division will monitor charges and payments from current claims on an ongoing basis and adjust the CCRs and payments as needed during the rate year to ensure appropriate payments. Adjustment of payments would include repricing Medicaid/NJ FamilyCare claims for the rate year.

(e) (No change.)

(f) In cases in which a hospital failed to notify the Division of changes to the hospital's charge structure 30 days prior to implementation, the hospital shall pay for all costs associated with reprocessing its claims, as well as the recovery of the related overpayments and interest related to those overpayments. Reprocessing shall apply to both Medicaid/NJ FamilyCare and charity care claims. Repeated occurrences of the failure to timely notify the Division of hospital CCR changes will be forwarded to the State's Medicaid Inspector General for review and possible referral to the Office of the Attorney General's Division of Criminal Justice for legal action.

10:52-14.12 Day outlier payment calculation for alternate level of care days

(a)-(b) (No change.)

(c) The day outlier payment is the number of alternate level of care days from the formula in (b) above multiplied by the annual nursing facility per diem rate set by the Facility Rate Setting program of the Division of Aging Services in the Department of Human Services.

(d)-(e) (No change.)

10:52-14.17 Appeal of the hospital's Medicaid/NJ FamilyCare final rate

(a) (No change.)

(b) Each hospital, within 15 working days of receipt of its Medicaid/NJ FamilyCare 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/NJ FamilyCare 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/NJ FamilyCare 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. (No change.)

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/NJ FamilyCare inpatient reimbursement for the rate year.

4. (No change.)

(d)-(e) (No change.)

(a)

CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND COMMISSION

Catastrophic Illness in Children Relief Fund Program

Adopted New Rules: N.J.A.C. 10:155

Proposed: February 21, 2017, at 49 N.J.R. 317(a).

Adopted: December 6, 2017, by the Catastrophic Illness in Children Relief Fund Commission, Executive Director, Claudia L. Marchese, Esq.

Filed: February 21, 2018, as R.2018 d.103, **with a non-substantial change** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 26:2-148 et seq., specifically 26:2-159.

Effective Date: May 21, 2018.

Expiration Date: May 21, 2025.

Summary of Public Comment and Agency Response:

COMMENT: A joint comment submitted by Diana MTK Autin, Executive Co-Director of SPAN and Lauren Agoratus, NJ Coordinator—Family Voices at SPAN objected to the elimination of payments for leased vehicles.

RESPONSE: In response to the comment, the Commission will not be adopting the proposed amendment at N.J.A.C. 10:155-1.7(b). The Commission did not intend to eliminate payments for leased vehicles, and will continue to cover the cost of vehicle modifications, whether the vehicle is leased or purchased.

Federal Standards Statement

A Federal standards analysis is not required because the requirements of this rulemaking are dictated by State statutes and are not subject to Federal requirements or standards.

Full text of the expired rules adopted herein as new rules follows (additions to proposal indicated in boldface with asterisks ***thus***):

SUBCHAPTER 1. CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND PROGRAM

10:155-1.2 Definitions

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

…

"Catastrophic illness" means any illness or condition for which the incurred medical expenses are not covered by any other source, including, but not limited to, other State or Federal agency programs, insurance contracts, trusts, proceeds from fundraising, or settlements relative to the medical condition of a child that is equal to 10 percent of the first $100,000 of annual income of a family plus 15 percent of the excess income over $100,000.

…

"Eligibility standard" means that dollar amount equal to 10 percent of the first $100,000 of annual income of a family plus 15 percent of the excess income over $100,000.

"Executive director" means the professional employed by the Commission, in accordance with New Jersey Civil Service Commission procedures, to administer the Fund on a day-to-day basis on behalf of the Commission.

…

"Local agency" means the Special Child Health Services Office responsible for assisting families in the application process, forwarding applications to the State Office, and making appropriate referrals to other State programs and benefits.

...

10:155-1.4 Initial application process

Applications may be submitted on a year-round basis to the local agency. The name, address, and phone number for the local agencies shall be available from the State Office. The local agency shall forward