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State/Territory Name: **NEW JERSEY**

State Plan Amendment (SPA) #: **11-11**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

OCT 24 2013

Harr
c: Keevey
Lovell
Czornyj
McMullen
Popkin
Hubbs
Lind

Valarie Harr
Director
Department of Human Services
Division of Medical Assistance and Health Services
State of New Jersey
P.O. Box 712
Trenton, New Jersey 08625-0712

RE: New Jersey 11-11

Dear Ms. Harr:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 11-11. Effective October 1, 2011 this amendment eliminates payment for potentially preventable conditions.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that TN 11-11 is approved effective October 1, 2011 and I have enclosed the CMS-179 and the approved plan pages.

If you have any questions, please call Tom Brady at 518-396-3810 x109 or Rob Weaver at 410-786-5914.

Sincerely,

[redacted]

Cindy Mann
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 11-11-MA

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 2702 of the Patient Protection and Affordable Care Act and 42 CFR 434, 438, and 447

7. FEDERAL BUDGET IMPACT
a. FFY 2012 [$ 5.98 million]
b. FFY 2013 [$ 8.14 million]

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19 A Table of Contents	**Same**
Attachment 4.19 A page 1-252-1-253	**Same**
Attachment 4.19 A page 1-254	**New**
Attachment 4.19 A page VI-1- VI-4	**New**
Attachment 4.19 B page 1	**Same**
Attachment 4.19 B page 29-32	**New**

10. SUBJECT OF AMENDMENT:
Payment Adjustment for Provider Preventable Conditions

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Jennifer Velez

14. TITLE: Commissioner

15. DATE SUBMITTED:
Revised 179 - Originally Submitted 9/29/11

16. RETURN TO:
Valerie Harr, Director
Division of Medical Assistance and Health Services
P.O. Box 712, #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 24 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 01 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy & Financial Mgt, CMS

23. REMARKS:

FORM CMS-179

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

REIMBURSEMENT FOR HOSPITAL SERVICES ATTACHMENT 4.19-A

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TN No. 11-11 MA (NJ) **Approval Date:** OCT 24 2013

Supersedes: TN 09-02 MA (NJ) **Effective Date:** OCT 01 2011

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of New Jersey

BASIS OF PAYMENT – HOSPITALS REIMBURSED UNDER THE DIAGNOSIS RELATED GROUPS (DRG) SYSTEM – INPATIENT SERVICES

For discharges occurring on or after October 1, 2011, regarding provider preventable conditions, acute care inpatient hospital claims with diagnoses not present on admission (POA) or where documentation is insufficient to determine if the conditions were present at the time of inpatient admission, or where the diagnosis is not used by the Division of Medical Assistance and Health Services, will not result in the assignment of claims to Diagnosis Related Groups (DRGs) that have higher payments. Instead, the claims will be paid as though the diagnoses were not present. This applies to provider preventable conditions (PPC) not simply any diagnosis which is not present on admission (POA). PPC's shall include Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) in accordance with 42 CFR 447 subpart A.

Acute Care Inpatient hospitals must use one of the following Medicare based POA Indicator for every diagnosis on the Uniform Billing (UB) claim form. Claims received without a POA Indicator will be denied. The following are the POA Indicator options and definitions:

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. DMAHS will utilize the diagnosis code in the assignment of the DRG for those diagnoses that are coded as "Y" for the POA Indicator.
N	Diagnosis was not present at time of inpatient admission. DMAHS will not utilize the diagnosis code in the assignment of the DRG for those selected HCAC diagnoses that are coded as "N" for the POA Indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. DMAHS will not utilize the diagnosis code in the assignment of the DRG for those selected HCAC diagnoses that are coded as "U" for the POA Indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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REIMBURSEMENT FOR HOSPITAL SERVICES

DMAHS will include the diagnosis in the assignment of the DRG for those diagnoses that are coded as "W" for the POA Indicator.

1 Unreported/ not used

- DMAHS will include the diagnosis in the assignment of the DRG for those diagnoses that are coded as "1" if those diagnoses are exempt from POA reporting under ICD-9-CM
- For diagnosis codes described at Section 1886(d)(4)(D)(iv) of the Social Security Act, DMAHS will not utilize the diagnosis in the assignment of the DRG for those diagnoses that are coded as "1"
- DMAHS will deny a claim where the POA indicator is coded as "1" and the diagnosis code does not appear on the ICD-9-CM Official Guidelines for Coding and Reporting

The diagnosis codes matching CMS/ Medicare's final rule are included in 42 CFR Parts 434, 438, &447 [CMS-2400-F]. For the most current list of excluded diagnosis codes, DMAHS will utilize the most recent update to Section 5001(c) of the Deficit Reduction Act of 2005.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Inpatient Reimbursement for General Acute Care Hospitals

Pages I-254 through I-259 are intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of New Jersey

REIMBURSEMENT FOR HOSPITAL SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: ALL INSTITUTIONAL SERVICES

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

_X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of New Jersey

REIMBURSEMENT FOR HOSPITAL SERVICES

Reimbursement for all inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider-Preventable Conditions are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

Beginning October 1, 2011, all institutions as defined in Attachment 4.11-A of the State Plan must use particular coding options which will be used by DMAHS to determine the existence of HCAC and OPPC. Methodology for HCAC and OPPC for acute care hospitals' inpatient claims is laid out in Section I of the Reimbursement for Hospital Services Attachment 4.19-A of the State Plan. For all non-acute, Hospital based Rehabilitation, and Hospital based Psychiatric institutions, the methodology and procedures for identifying HCAC and OPPC are as follows:

HCAC: all institutions must use one of the Medicare based POA Indicators for every diagnosis on the Uniform Billing (UB) claim form for all inpatient claims. Claims received without a POA Indicator will be denied. The POA indicator options and definitions are as follows:

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if the condition was present at the time of the inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/not used.

- DMAHS will deny a claim where the POA indicator is coded as "1" and the diagnosis code does not appear on the ICD-9-CM Official Guidelines for Coding and Reporting

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of New Jersey

REIMBURSEMENT FOR HOSPITAL SERVICES

The diagnosis codes matching CMS/Medicare's final rule can be located at 42 CFR Parts 434, 438, & 447 [CMS-2400-F]. For the most current list of excluded diagnosis codes, DMAHS will utilize the most recent update to Section 5001(c) of the Deficit Reduction Act of 2005.

DMAHS will retroactively review all paid non-acute, hospital-based psychiatric and hospital-based rehabilitation claims with diagnoses coded with N, U, or 1 indicators.

- DMAHS will compare all diagnoses with N, U, or 1 indicators to the HCACs identified in 42 CFR 447.
- If an N or U diagnosis is included on the HCAC list, DMAHS will cut back portions of the per diem payment related to the diagnosis if such costs can be reasonably identified.
- For diagnoses with indicators of 1, DMAHS will also recover portions of the per diem payment related to the diagnosis if such diagnosis codes are also described at Section 1886(d)(4)(D)(iv) of the Social Security Act and such costs can be reasonably identified.
- DMAHS shall seek no recovery related to an indicator of 1 if such diagnoses are exempt from POA reporting under ICD-9 CM.

In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.

Other Provider Preventable Conditions (OPPCs): No payment shall be made for inpatient services for OPPCs. OPPCs are the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

OPPCs will be identified by DMAHS using External Cause of Injury (ECI) Codes listed on the UB. Specifically, the three Medicare National Coverage Determinations as defined above will be reported to DMAHS using one of the following three ECI codes:

E876.5 – Performance inappropriate operation/invasive procedure (wrong operation/ correct patient)

E876.6 – Performance of operation/invasive procedure on patient not scheduled

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State of New Jersey

REIMBURSEMENT FOR HOSPITAL SERVICES

E876.7 – Performance of correct operation/invasive procedure on wrong side/body part

Provider payments shall be retroactively reviewed by DMAHS. DMAHS will recoup all money identified for any services the provider rendered that are deemed to have been associated with the ECI diagnosis itself or a lengthened stay due to the ECI diagnosis. The day count eligible for this recoupment will be calculated using occurrence codes/ date spans as provided on the UB for preliminary stays, and an average length of stay (ALOS) for subsequent services rendered by the original provider as a result of the ECI diagnosis

If an OPPC existed for a patient prior to the initiation of treatment, payment will be made at standard rates to the provider for the treatment of the patient's condition.
Provider payments shall be reduced if:

- the identified OPPC would result in an increase in payment or
- the portion of the payment related to the treatment of the OPPC can be reasonably isolated.

Non-payment of other provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the OPPC implementation period, the State shall adjust reimbursements according to the methodology above.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

The reimbursement methodologies for the following services are contained in this attachment.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

_X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

OTHER PROVIDER-PREVENTABLE CONDITIONS:

OUTPATIENT HOSPITAL SERVICES

No payment shall be made for certain outpatient hospital services for OPPCs. OPPCs are the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

OPPCs will be identified by DMAHS using External Cause of Injury (ECI) Codes listed on the UB. Specifically, the three Medicare National Coverage Determinations as defined above will be reported to DMAHS using one of the following three ECI codes:

E876.5 – Performance inappropriate operation/invasive procedure (wrong operation/correct patient)

E876.6 – Performance of operation/invasive procedure on patient not scheduled

E876.7 – Performance of correct operation/invasive procedure on wrong side/body part

If an OPPC existed for a patient prior to the initiation of treatment, payment will be made at standard rates to the provider for the treatment of the patient's condition.

Provider payments shall be retroactively reviewed by DMAHS. DMAHS will recoup all money identified for any services the provider rendered that are deemed to have been associated with the ECI diagnosis itself or a lengthened stay due to the ECI diagnosis.

Provider payments shall be reduced if:

- the identified OPPC would result in an increase in payment or
- the portion of the payment related to the treatment of the OPPC can be reasonably isolated.

Non-payment of other provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

In the event that individual cases are identified throughout the OPPC implementation period, the State shall adjust reimbursements according to the methodology above.

ALL OTHER NON-INSTUTUTIONAL SERVICES

Reimbursement for all non-institutional services shall be based on the Other Provider Preventable Conditions (OPPC) policy defined in 42 CFR 447.26.

Payments for claims with service dates on or after October 1, 2011 to providers of non-institutional services, including ambulatory surgical centers, practitioners, and independent clinics, for treatments related to HCACs, as determined by the diagnosis codes, shall be subject to recovery actions by DMAHS. Provider payments shall be reduced retroactively using internal routine monitoring and cross referencing. DMAHS will recoup all money identified for all services the provider provided that is deemed to have been associated with the following three ECI diagnosis codes:

E876.5 – Performance inappropriate operation/invasive procedure (wrong operation/correct patient)

E876.6 – Performance of operation/invasive procedure on patient not scheduled

E876.7 – Performance of correct operation/invasive procedure on wrong side/body part

Payments for claims with service dates on or after October 1, 2011 to providers of non-institutional services, including ambulatory surgical centers, practitioners, dentists and independent clinics for treatments related to OPPCs shall be denied by DMAHS. OPPCs are the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

OPPCs shall be identified by DMAHS using the appropriate National Coverage Determination modifier(s) described below reported by providers with all relevant HCPCS procedure codes related to treatment of the OPPC.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES: NON-INSTITUTIONAL SERVICES

Procedure Code Modifier	Modifier Description
PA	Surgery wrong body part/invasive procedure
PB	Surgery wrong patient/invasive procedure
PC	Wrong surgery on patient/invasive procedure

Non-payment of OPPCs shall not prevent access to services by Medicaid beneficiaries. In the event that individual cases are identified throughout the PPC implementation period, the State shall adjust reimbursements according to the methodology above.